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IMPACT OF FEDERAL SPENDING CUTS ON MATERNAL AND CHILD HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON ECONOMIC GOALS AND INTERGOVERNMENTAL POLICY

OF THE

JOINT ECONOMIC COMMITTEE

CONGRESS OF THE UNITED STATES

NINETY-EIGHTH CONGRESS

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IMPACT OF FEDERAL SPENDING CUTS ON MATERNAL AND CHILD HEALTH CARE

THURSDAY, NOVEMBER 17, 1983

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON ECONOMIC GOALS
AND INTERGOVERNMENTAL POLICY OF THE
JOINT ECONOMIC COMMITTEE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room SD–628, Dirksen Senate Office Building, Hon. Lloyd Bentsen (vice chairman of the subcommittee) presiding.

Present: Senator Bentsen.

Also present: Charles H. Bradford, assistant director; and George R. Tyler, professional staff member.

OPENING STATEMENT OF SENATOR BENTSEN, VICE CHAIRMAN

Senator BENTSEN. This hearing will come to order.

This is the second in a series of hearings in which I am exploring the state of child and maternal health care in our Nation. This specific hearing is designed to explore the impact of the 1981 spending cuts in the Federal maternal and child health block grant program.

During the first hearing on November 2, this subcommittee heard from several child health experts who presented what I believe is very convincing evidence that the mix of infant-oriented government health care programs has been effective. There has been a firm and striking link between the growth of Federal prenatal care programs and reduced infant mortality. In fact, the Federal child and maternal health care programs can be credited with doubling the rate of success over the last decade in shrinking the likelihood of tragic infant deaths. These programs have been cost-effective, as well as medically effective.

The California OB program, for example, saves about $5 in hospital costs for each $1 spent on prenatal care. And the New York children and youth and maternity and infant care project saved about $2 for every $1 spent.

Both of these cost-effective projects are funded under title V, maternal and child health block grant. Yet, maternal and child health funding was cut substantially in 1981 at the request of, and under heavy pressure from, the administration. I opposed those cuts. And I was successful in rolling the old title V program into a separate and more defensible and visible block grant.

That visibility was helpful last year when Congress overrode administration's objections and added back substantial funds to the maternal and child health care block grant as one component of the health bill.

But the battle is not over. Last winter, the administration again tried to shortchange maternal and child health programs in the fiscal year 1984 budget by freezing the authorization level at the old level for 1982. I am going to try to correct that shortly by restoring higher authorization funding levels to the MCH program.

My efforts to protect the maternal and child health program are based on its success, both in saving lives and in saving taxpayer dollars. About 6 in every 100 American babies are born underweight. Most require extensive and very expensive care, costing as much as $100,000 per child. Yet, MCH programs have been able, in some instances, to cut the incidence of low birthweight babies by 40 percent, by providing quality prenatal care. They are saving millions of dollars in private and medicaid medical costs, and avoiding untold suffering for babies and their parents.

If you were the toughest, hardest-minded fiscal conservative, you cannot help but see the economic and human sense made by these kinds of expenditures. But beyond their cost effectiveness, if you give any thought to the emotions and the problems and concerns for the parents of such children, you would understand how critical and how important these programs are.

I have a written opening statement that I will enter into the record, together with a statement by Senator Levin, who could not be here today, due to scheduling.

[The written opening statement of Senator Bentsen and the written statement of Senator Levin follow:]

Written Opening Statement of Senator Bentsen

LADIES AND GENTLEMEN:

THIS IS THE SECOND HEARING IN A SERIES EXPLORING THE STATE OF CHILD AND MATERNAL HEALTH CARE IN OUR NATION. THE HEARING IS DESIGNED TO EXPLORE THE IMPACT OF THE 1981 SPENDING CUTS IN THE FEDERAL MATERNAL AND CHILD HEALTH BLOCK GRANT PROGRAM.

DURING THE FIRST HEARING IN THIS SERIES, ON NOVEMBER 2, THIS COMMITTEE HEARD FROM SEVERAL CHILD HEALTH EXPERTS WHO PRESENTED WHAT I BELIEVE IS VERY CONVINCING EVIDENCE THAT THE MIX OF INFANT-ORIENTED GOVERNMENT HEALTH CARE PROGRAMS HAS BEEN EFFECTIVE. THERE HAS BEEN A FIRM AND STRIKING LINK BETWEEN THE GROWTH OF FEDERAL PRENATAL CARE PROGRAMS AND REDUCED INFANT MORTALITY. IN FACT, THE FEDERAL CHILD AND MATERNAL HEALTH CARE PROGRAMS CAN BE CREDITED WITH DOUBLING THE RATE OF SUCCESS OVER THE LAST DECADE IN SHRINKING THE LIKELIHOOD OF TRAGIC INFANT DEATHS. THESE PROGRAMS HAVE BEEN COST EFFECTIVE, AS WELL AS MEDICALLY EFFECTIVE. THE CALIFORNIA OB PROGRAM, FOR EXAMPLE, SAVES ABOUT $5 IN HOSPITAL COSTS FOR EACH $1 SPENT ON PRENATAL CARE. AND, THE NEW YORK CHILDREN AND YOUTH AND MATERNITY AND INFANT CARE PROJECT SAVED $2 FOR $1 SPENT.

BOTH THESE COST-EFFECTIVE PROJECTS ARE FUNDED UNDER THE TITLE 5, MATERNITY AND CHILD HEALTH BLOCK GRANT. YET, MATERNITY AND CHILD HEALTH FUNDING WAS CUT ALMOST 20 PERCENT IN 1981 AT THE REQUEST OF, AND UNDER

HEAVY PRESSURE FROM, THE ADMINISTRATION. I OPPOSED THOSE CUTS. AND I WAS SUCCESSFUL IN ROLLING THE OLD TITLE 5 PROGRAM INTO A SEPARATE AND MORE DEFENSIBLE BLOCK GRANT. THAT VISIBILITY WAS HELPFUL LAST YEAR WHEN CONGRESS OVERRODE ADMINISTRATION OBJECTIVES AND ADDED BACK SOME FUNDS TO THE MATERNAL AND CHILD HEALTH BLOCK GRANT AS ONE COMPONENT OF THE JOBS BILL. BUT THE BATTLE WAS NOT OVER. LAST WINTER, THE ADMINISTRATION AGAIN TRIED TO SHORT-CHANGE MATERNAL AND CHILD HEALTH PROGRAMS IN THE FY84 BUDGET BY FREEZING THE AUTHORIZATION LEVEL AT THE LEVEL SET IN 1982. I AM TRYING TO CORRECT THAT INADEQUATE AUTHORIZATION LEVEL NOW WITH AN AMENDMENT TO RESTORE $105 MILLION TO THE M-C-H PROGRAM.

MY EFFORTS TO PROTECT THE MATERNAL AND CHILD HEALTH PROGRAM ARE BASED ON ITS SUCCESS BOTH IN SAVING LIVES AND IN SAVING TAXPAYER DOLLARS. ABOUT SIX IN ONE HUNDRED AMERICAN BABIES ARE BORN UNDERWEIGHT. MOST REQUIRE EXTENSIVE AND VERY EXPENSIVE CARE, COSTING AS MUCH AS $100,000 PER CHILD. YET, M-C-H PROGRAMS HAVE BEEN ABLE IN SOME INSTANCES TO CUT THE INCIDENCE OF LOW BIRTHWEIGHT BABIES BY 40 PERCENT, BY PROVIDING QUALITY PRENATAL CARE. THEY ARE SAVING MILLIONS OF DOLLARS IN PRIVATE AND MEDICAID MEDICAL COSTS, AND AVOIDING UNTOLD SUFFERING FOR BABIES AND THEIR PARENTS.

YET, THESE PROGRAMS HAVE BEEN CUT SOME 22 PERCENT IN REAL TERMS BY THE ADMINISTRATION BETWEEN FISCAL YEARS 1981 AND 1984. THE IMPACT HAS BEEN SUBSTANTIAL, WITH NUMEROUS INDICATORS OF MATERNAL AND INFANT HEALTH TURNING DOWN FOR THE FIRST TIME IN DECADES. THE INCIDENCE OF LOW BIRTH WEIGHT BABIES IS ON THE RISE NOW IN STATES AS VARIED AS UTAH AND NEW HAMPSHIRE. AND, IN DATA JUST RELEASED THIS MORNING TO THE COMMITTEE BY THE FOOD RESEARCH AND ACTION CENTER, AT LEAST NINE STATES HAVE EXPERIENCED A COMPLETE REVERSAL IN INFANT DEATH TRENDS. IN THESE NINE STATES, INFANT MORTALITY STATISTICS AND THE NUMBER OF INFANT DEATHS ROSE IN 1982 FOR THE FIRST TIME IN YEARS. THIS TRAGIC

RISE IN INFANT DEATHS IS WIDESPREAD AND PERVASIVE. AS WE SEE ON THIS ATTACHED CHART, RISING INFANT MORTALITY IS NOT CONCENTRATED IN ANY ONE REGION. THREE OF THE STATES ARE IN NEW ENGLAND. THREE ARE IN THE SOUTH. AND THREE ARE IN THE WEST. THE LIST WILL GROW AS DATA FLOWS IN FROM THE 15 STATES STILL COMPILING STATISTICS.

THERE IS NO DOUBT IN MY MIND THAT THE 1982 REDUCTION IN FEDERAL CHILD AND MATERNAL HEALTH FUNDING HAS PLAYED A MAJOR ROLE IN THE RISING TIDE SINCE THEN OF NEEDLESS INFANT DEATHS. MAGNIFYING THIS TRAGEDY HAS BEEN THE ECONOMIC DOWN-TURN WHICH THREW MILLIONS OF MEN AND WOMEN OUT OF WORK AND OFF INSURANCE ROLLS. THEY WERE FORCED TO RELY ON OUR PUBLICLY FUNDED HEALTH INFRASTRUCTURE AT THE PRECISE TIME THAT INFRASTRUCTURE WAS BEING REDUCED HERE IN WASHINGTON. IF THERE WERE EVER A WRONG TIME AND PLACE TO REDUCE ACCESS TO MEDICAL HELP FOR MATERNITY CARE, IT WAS IN THE MIDST OF OUR WORST POST-WAR RECESSION. WE BEGAN TO PAY THE PRICE IN 1982. AND MANY INFANTS AND FAMILIES WILL BE PAYING A HEAVY FINANCIAL AND EMOTIONAL PRICE FOR A GENERATION TO COME.

OUR NATION DOES A POOR JOB OF COLLECTING MEDICAL DATA. AND THE MAGNITUDE OF THE IMPACT OF THE M-C-H BLOCK GRANT CUTS IN 1982 IS ONLY BEGINNING TO TRICKLE IN. THE INFANT MORTALITY DATA RELEASED HERE TODAY HAVE JUST BEEN COMPILED -- AND ARE ONLY AVAILABLE FOR 35 STATES SO FAR. THEY REVEAL THAT OUR NATION'S PROUD ADVANCE TOWARD IMPROVED INFANT HEALTH HAS STALLED -- AND TURNED INTO A RETREAT. BUT THESE NUMBERS DISGUISE THE REAL TRAGEDY OF NEEDLESSLY HANDICAPPED AND DYING INFANTS. IT IS DIFFICULT TO DEAL WITH THIS TOPIC WITHOUT EMOTION. BUT THE CONGRESS MUST DO THAT -- MUST LOOK BEHIND THE NUMBERS TO LEARN EXACTLY WHAT THE IMPACT OF THE 1982 M-C-H BLOCK GRANT CUTS HAVE BEEN.

TO DO THAT, WE HAVE ASSEMBLED A DISTINGUISHED GROUP OF MEDICAL EXPERTS FROM ACROSS THE NATION. DR. GLORIA SMITH IS THE DIRECTOR OF MICHIGAN'S

HEALTH DEPARTMENT -- A STATE HIT DOUBLY HARD BY PROGRAM CUTS AND THE RECESSION. DR. SMITH IS RELEASING A REPORT HERE THIS MORNING ON THE IMPACT OF THE MCH PROGRAM CUTS AND STEPS BEING TAKEN IN MICHIGAN TO IMPROVE CHILD AND MATERNAL HEALTH. SHE WILL BE JOINED BY MS. SARA ROSENBAUM WITH THE CHILDREN'S DEFENSE FUND HERE IN WASHINGTON; BY DR. RICHARD NELSON FROM THE UNIVERSITY OF MINNESOTA AND GILLETTE CHILDREN'S HOSPITAL; BY DR. KENNETH OSGOOD OF LAS VEGAS, NEW MEXICO, WHO IS APPEARING ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS; BY DR. ARTHUR SALISBURY, VICE PRESIDENT OF THE MARCH OF DIMES, AND BY DR. JOSEPHINE GITTLER OF THE UNIVERSITY OF IOWA AND CO-DIRECTOR OF THE NATIONAL MATERNAL AND CHILD HEALTH RESOURCE CENTER.

I AM PLEASED THAT EACH OF YOU CAN BE WITH US TODAY.

INFANT MORTALITY

(per 1,000 live births)

1978-1982

	1978	1981	1982
Alabama	16.1	12.9	13.8
Nebraska	13.0	9.9	10.0
New Hampshire	10.0	9.7	11.0
North Carolina	16.6	13.2	13.7
Massachusetts	11.0	9.6	10.1
Oklahoma	14.1	11.8	12.3
Utah	11.4	9.8	11.0
Vermont	13.3	7.9	9.1
Virginia	13.5	12.6	12.9

Food Research and Action Center

Written Statement of Hon. Carl Levin, a U.S. Senator from the State of Michigan

Mr. Chairman. Thank you for the opportunity to submit testimony to the Joint Economic Committee regarding the need for an adequate level of federal funding for maternal and child health care services. The Committee will be hearing today from a number of health experts, including Dr. Gloria R. Smith, the Director of the Michigan Department of Public Health. We in the State are extremely fortunate to have her as the Director of the Department and as a spokeswoman today on public health care needs in Michigan.

Dr. Smith will present a report compiled by the Michigan Department of Public Health which includes recommendations on what steps should be taken by the Federal Government to safeguard the health of mothers and children throughout the country who are at risk because of their lack of economic resources. The primary recommendation of the Department is that funding for the Maternal and Child Health Care Block Grant -- which has experienced a roughly 21% cut in real funding since 1981 -- be doubled during the upcoming fiscal year. In this regard, I am pleased to be a cosponsor of Senator Bumpers' bill, S. 2013, which would authorize appropriations for the Maternal and Child Health Care Block Grant consistent with the amount appropriated during FY 1983, so that direct services will remain constant.

The Omnibus Reconciliation Bill which is currently under consideration by the Senate provides an authorization level of $452 million during FY 1984 for the MCH block grant. Although this would appear to be an increase over the current authorization level of $373 million, it would in fact represent a substantial cut in the amount appropriated for maternal and child health services. This is because in addition to the MCH grant money, the Jobs Bill passed by the Congress last year to meet emergency needs resulting from unemployment provided an additional appropriation of $105 million for the Maternal and Child Health Care Block Grant. That brought the total appropriation for the block grant in FY 1983 to $478 million.

IN APPROVING THE JOBS BILL, THE CONGRESS RECOGNIZED THE NEED TO ENSURE ADEQUATE FUNDING TO PROVIDE VITAL HEALTH CARE SERVICES TO THE UNEMPLOYED AND THEIR FAMILIES. BUT THAT MONEY FROM THE JOBS BILL ISN'T AVAILABLE FOR FY84. AS A RESULT, MATERNAL AND CHILD CARE SPENDING WILL DROP BY $26 MILLION.

THE NATION CONTINUES TO EXPERIENCE HIGH UNEMPLOYMENT. WHILE THE "ECONOMIC RECOVERY" HAS LOWERED THE NATIONAL UNEMPLOYMENT RATE TO ABOUT 9%, THE STATE OF MICHIGAN CONTINUES TO EXPERIENCE ALMOST 14% UNEMPLOYMENT, WITH 577,000 PEOPLE OUT OF WORK. THE UNEMPLOYED IN MICHIGAN AND THROUGHOUT THE COUNTRY WILL SUFFER AS A RESULT OF THE PROPOSED CUT IN FUNDING FOR THE MATERNAL AND CHILD HEALTH CARE BLOCK GRANT. THOSE WHO TRADITIONALLY HAVE RELIED UPON PRIVATE HEALTH INSURANCE COVERAGE CAN'T AFFORD IT WHEN THEY'RE OUT OF WORK AND NOW RELY ON PUBLIC HEALTH CARE PROGRAMS SUCH AS THE MATERNAL AND CHILD HEALTH CARE PROGRAMS. IF THEY ARE TURNED AWAY, THE NATION AS A WHOLE WILL LOSE. MANY ARE SUFFERING ALREADY.

FOR EXAMPLE, BETWEEN 1980 AND 1981, MICHIGAN'S INFANT MORTALITY RATE INCREASED FROM 12.8 PERCENT DEATHS PER 1,000 LIVE BIRTHS TO 13.2 PERCENT DEATHS PER LIVE BIRTHS. ACCORDING TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH, THIS WAS THE GREATEST INCREASE IN INFANT MORTALITY RATES IN THE STATE SINCE WORLD WAR II. FORTUNATELY, BETWEEN 1982 AND 1983, THE STATE AS A WHOLE EXPERIENCED A DOWNWARD TREND IN THE INFANT MORTALITY RATE. HOWEVER, IN THE CITY OF DETROIT, WHERE UNEMPLOYMENT IS SIGNIFICANTLY HIGHER THAN IN THE STATE AS A WHOLE, THE INFANT MORTALITY RATE REMAINS SHOCKINGLY HIGH -- AT 21.8%.

EVERY FEDERAL DOLLAR SPENT ON MATERNAL AND CHILD HEALTH CARE PRODUCES SAVINGS FOR THE FEDERAL GOVERNMENT IN THE LONG-RUN. BY PROVIDING PRENATAL CARE, MATERNAL AND CHILD HEALTH CARE PROGRAMS HELP PREVENT THE MUCH COSTLIER INCIDENCE OF LOW-BIRTH WEIGHT BABIES. APART FROM PREVENTING THE SUFFERING OF INFANTS AND THEIR PARENTS THAT RESULTS FROM SERIOUS HEALTH PROBLEMS AT BIRTH, THE MATERNAL AND CHILD HEALTH CARE PROGRAMS PROVIDE A MEANS TO MONITOR THE DEVELOPMENT OF INFANTS AFTER BIRTH. THIS MONITORING CAN HELP THESE CHILDREN TO GROW UP LEADING HEALTH AND PRODUCTIVE LIVES.

I COMMEND SENATOR BENTSEN FOR HOLDING THIS HEARING. I HOPE THAT DOCUMENTATION OF BOTH EXAMPLES OF CURRENTLY UNMET NEEDS AND THE PROGRESS MADE AS A RESULT OF PROVIDING HEALTH SERVICES TO MOTHERS AND INFANTS WILL STIMULATE THE CONGRESS TO APPROVE THE BUMPERS LEGISLATION TO INCREASE THE AUTHORIZATION FOR THE MATERNAL AND CHILD HEALTH CARE BLOCK GRANT DURING FISCAL YEAR 1984.

Senator BENTSEN. Senator Bumpers has been one of the Senators most in the forefront of the fight to preserve the MCH program—he has repeatedly shown his care and his concern and his compassion for this particular program to his great credit. And I am most appreciative of having him here this morning.

Senator Bumpers.

STATEMENT OF HON. DALE BUMPERS, A U.S. SENATOR FROM THE STATE OF ARKANSAS

Senator BUMPERS. Mr. Chairman, first of all, let me congratulate you on holding these hearings which, as far as I know, are almost unprecedented, particularly for this committee. To involve itself in what I consider one of the really serious issues confronting Congress is commendable.

I am not going to belabor the clinical aspects of this too much because you have a very distinguished panel that is about to appear before you who will give you that kind of very definitive information from a statistical and clinical standpoint.

But I would just start off by saying that what we are talking about here is a preventive health care program. Something that this country never seems to understand is the vitality and the efficacy of those kinds of programs.

Hubert Humphrey, and I know you have heard him make the same speech, said that people talk about national health insurance. But it is not national health insurance he would remind us; it is national sick insurance. It does not do anything until you get sick.

The maternal and child health care programs are designed, of course, to prevent illness and to save us untold billions of dollars in institutionalized care for children and adults.

The MCH block grant provides States with the ability to reduce infant mortality, to improve and promote the health of mothers and infants and children. It also provides funds for medically necessary services to handicapped children. Ten percent of the funds is set aside for projects such as genetic screening and counseling, hemophilia programs, and pediatric pulmonary centers.

Federal programs rarely have such a clearly stated mandate. What is even more unusual is that these programs actually achieve the goals that have been mandated and they do so in a cost effective fashion.

Few Federal programs can claim success equal to that of the MCH block grant programs. Certainly, there have been problems. And yet, with these programs in place, we have seen a 40-percent drop in infant mortality rates since 1965. Large-scale immunization programs funded in part by MCH money have virtually eliminated smallpox and led to dramatic declines in the incidence of diphtheria, measles, polio, rubella, and tetanus. Other indicators of the MCH block grant programs' impact are the sheer numbers of children who receive vision and hearing tests and dental checkups, and the number of children who receive rehabilitative services. These are children who would not have otherwise received those services. The block grant funds support a network of clinics which provide approximately 12 million mothers and children with health services.

Preventive and primary health care services are cost-effective because they reduce the need for more costly health services in the future.

For example, Alabama officials estimate that for every dollar spent on preventive maternal and child health care, the State saves between $5 and $10 on long-term institutional care for the severely retarded. A GAO study found that the costs of screening infants and the treatment of seven common disorders were less than one-eighth of the cost of an impaired child over a lifetime.

But sometimes we have difficulty grasping the concept behind long-term cost-effective programs like MCH. The need for immediate measures to reduce the budget deficit is the principal reason for the troubled history of this program in recent years. Despite the unquestioned value and importance of the MCH block grant, the program has been cut 33 percent in authorization levels since 1981. Tragically, these cutbacks have occurred during a period of increased demand for services. The recent recession has meant not only the loss of jobs, but also the loss of health insurance coverage. For increasing numbers of children, the programs funded by MCH are their only source for needed health services.

Last year, MCH block grant received an additional $105 million through the so-called jobs bill. Now the administration is arguing that there is no longer any need to maintain funding at a constant level, because the economy is in the middle of a recovery and that, as a consequence, the demand for maternal and child health services should have decreased.

This argument is specious, Mr. Chairman. The jobs bill money enabled States to restore cutbacks in services brought about by budget cuts of previous years. But the funds were insufficient to expand or increase services to meet the increased demand for service.

Indeed, a 1980 GAO study indicated that even before the cutbacks were made, insufficient funds precluded many States from offering services to all mothers and children who needed them. States have targeted the jobs bill funds for projects in areas of high need and high unemployment.

I must say that the problem we had with child health screening in Arkansas when I was Governor is what caught my interest, and has maintained it in this program. In Arkansas, the jobs bill money was used to provide prenatal care in a 13-county area where previously, pregnant women had no place to go. The recovery of the economy is not going to do anything to replace this service. In fact, there are still 22 counties in my State where prenatal services are not available at all.

It is tragic that these figures and others like them from practically every State in the country fail to move this administration. In Pulaski County—and that is Little Rock—one-half of the pregnant women who come to the maternity clinic for services are turned away. And those who do receive care have to wait as long as 5 weeks to see a doctor. There are eight counties in Arkansas which have no child health clinics and that leaves 45,000 children below the age of 18 without services.

We have heard that block grants usually result in a more efficient administration of each State's health services and therefore, allow for more effective delivery of those services. But the projected savings do not begin to offset the severe cuts in funding. In Arkansas, for example, the cuts in MCH funds came on top of State cuts which resulted in the loss of 130 employees.

We have heard that MCH is a State and local issue, that Federal initiatives are inappropriate, inefficient and ineffective. But we know that MCH programs have had a long and distinguished Federal his-

tory, beginning in 1935 with title V of the Social Security Act. In addition, at a time when the States are struggling to cope with medicaid cutbacks in eligibility, benefits and payments levels, they are financially unable to incur greater responsibility for MCH programs. In my State, one out of every four children lives in poverty. Yet, 60 percent of those children are ineligible for medicaid. In Arkansas, State agencies absorbed $400,000 of the $700,000 the State lost due to the cuts in MCH. And they cannot offset any further cuts.

Mr. Chairman, I want to digress from my testimony for a moment to give you an example. When we cut medicaid funds, the States were given some latitude and discretion about where they were going to make up those cuts and how they were going to trim their programs in light of those cuts. So, for example, a child on medicaid could only stay about 7 to 10 days in the hospitals of my State—that was one way that adjusted to the medicaid reduction.

Now if a child born in a poor area with a congenital heart defect could very easily require 2 to 3 months of hospital care. The local hospital, we will say in one of the rural communities of the State, would keep that child the 7 or 8 days, or whatever was permitted. But, in all probability, the child would then be transferred to the University of Arkansas Medical Center, simply because his or her medicaid stay had been used up, and the hospital would have to take that child as an indigent.

Fortunately, one of the things that you can do with MCH funds, of course, would be to fund the University of Arkansas Medical Center to take care of that very serious condition for that child. Indeed, MCH is the only source of funds available to the university medical center, or any other similar entity providing such care. Yet with MCH funds being reduced, hard choices need to be made.

And hard choices they are: Why do we put States in the position of having to choose between funding child health clinics or providing maternity clinics? We ask States to decide which is more important. What has the greatest return on the dollar: Sudden infant death programs or fluoridation treatment programs? At least these are questions that we have had to resolve in Arkansas.

What kind of government would ask a State to decide which of a child's health needs are most important? Clearly, this administration has set its priorities. When the administration looked for budget deficit reduction measures, it turned to further cuts in programs such as MCH.

It is time for Congress to define our priorities and to continue programs that we believe are just, fair, and cost effective. If we fail to act now to preserve the integrity of these programs, we are certainly going to bear an unbelievable cost later on.

I have introduced a bill to increase the level of funding authorized for MCH block grants from $373 million to $499 million.

Senator BENTSEN. And the chairman is one of your original cosponsors. I am very supportive of your efforts there.

Senator BUMPERS. Thank you very much, Mr. Chairman. And that is the bare minimum. That is the bare minimum necessary to fund these programs at the 1984 level. The MCH block grant is the only health care program specifically for children. The impact of the cuts so far have been devastating. Seldom do we see such stark and terrible results from our imprudent actions.

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Let me digress just a moment, Senator, to point out—as you have heard me talk about on the floor of the Senate, and I guess I will be talking about it on my deathbed—when I was Governor, Betty started an immunization program to try to get all the children in Arkansas immunized against childhood preventable diseases. This effort provides us with a very dramatic example of cost effectiveness. We immunized 300,000 children on two successive weekends. And the cost was virtually nothing because we used agencies that were already in existence, including the National Guard and the Extension Service. All of them combined to put this program together and make it a success. When I came to Washington, I worked very hard to put an immunization program in place and it became very successful at the national level. In Arkansas, we determined the costs of care for each child institutionalized, because of a childhood syndrome, from rubella, mumps, measles, and so on. The entire program, which over a 2-year period raised our immunization levels from about 76 percent to 98 percent, cost less than one-half of the cost of institutionalizing one infant for the rest of its life.

Senator BENTSEN. That is a dramatic example.

Senator BUMPERS. That is my testimony, Mr. Chairman. Again, I sincerely thank you and applaud your efforts for holding these hearings.

Senator BENTSEN. Thank you very much, Senator Bumpers. We are very pleased to have you.

Senator BUMPERS. If you have any questions, I will be happy to answer them.

Senator BENTSEN. Thank you. I know you have another hearing to attend, so we will move along to the witnesses.

Senator BUMPERS. Thank you very much.

[The prepared statement of Senator Bumpers follows:]

PREPARED STATEMENT OF HON. DALE BUMPERS

MR. CHAIRMAN, I WANT TO THANK YOU AND THE OTHER MEMBERS OF THE COMMITTEE FOR ALLOWING ME THE OPPORTUNITY TO SPEAK TODAY ON THE IMPACT OF THE BUDGET CUTS ON MATERNAL AND CHILD HEALTH CARE. FIRST, LET ME SAY THAT SENATOR BENTSEN AND HIS COMMITTEE HAVE DONE THE CONGRESS A GREAT SERVICE IN HOLDING THESE HEARINGS. THEY ARE TIMELY IN DRAWING ATTENTION TO THE PROBLEMS WE FACE IN THE UNITED STATES IN PROVIDING NEEDED HEALTH SERVICES TO MOTHERS AND CHILDREN. OUR CHILDREN'S HEALTH IS IN JEOPARDY, AND IF THE POLICIES OF THIS ADMINISTRATION CONTINUE, THEIR VERY LIVES WILL BE IN PERIL. OUR CONCERN FOR HELPLESS CHILDREN IS ABSOLUTELY BASIC TO OUR NATIONAL CHARACTER.

TODAY, THE COMMITTEE WILL HEAR TESTIMONY FROM A PANEL OF DISTINGUISHED EXPERTS WHO CAN DOCUMENT FAR BETTER THAN I THE UNMET NEED FOR MATERNAL AND CHILD HEALTH SERVICES, THE IMPORTANCE AND VALUE OF THE MATERNAL AND CHILD HEALTH (MCH) BLOCK GRANT PROGRAMS, AND THE DEVASTATING IMPACT THE BUDGET

CUTS HAVE HAD ON THOSE PROGRAMS. BUT THESE POINTS ARE SO IMPORTANT THEY BEAR REPEATING.

THE MCH BLOCK GRANT PROVIDES FUNDS TO THE STATES FOR SERVICES TO REDUCE INFANT MORTALITY AND TO IMPROVE AND PROMOTE THE HEALTH OF MOTHERS, INFANTS, AND CHILDREN. IT ALSO PROVIDES FUNDS FOR MEDICALLY NECESSARY SERVICES TO HANDICAPPED CHILDREN. TEN PERCENT OF THE FUNDS IS SET ASIDE FOR PROJECTS SUCH AS GENETIC SCREENING AND COUNSELING, HEMOPHILIA PROGRAMS, AND PEDIATRIC PULMONARY CENTERS. FEDERAL PROGRAMS RARELY HAVE SUCH A CLEARLY STATED MANDATE. IT IS MORE UNUSUAL THAT THEY ACTUALLY ACHIEVE THE GOALS MANDATED BY FEDERAL LEGISLATION, AND THAT THEY DO SO COST-EFFECTIVELY. FINALLY, FEW FEDERAL PROGRAMS CAN CLAIM SUCCESS EQUAL TO THAT OF THE MCH BLOCK GRANT PROGRAMS. CERTAINLY, THEY HAVE NOT BEEN WITHOUT THEIR PROBLEMS. YET WITH THESE PROGRAMS IN PLACE, WE HAVE SEEN A 40 PERCENT DROP IN INFANT MORTALITY RATES SINCE 1965; LARGE SCALE IMMUNIZATION PROGRAMS FUNDED IN PART BY MCH MONIES HAVE VIRTUALLY ELIMINATED SMALLPOX AND HAVE LED

TO DRAMATIC DECLINES IN THE INCIDENCE OF DIPHTHERIA, MEASLES, WHOOPING COUGH, POLIO, RUBELLA AND TETANUS. OTHER INDICATORS OF THE MCH BLOCK GRANT PROGRAMS' IMPACT ARE THE SHEER NUMBERS OF CHILDREN WHO RECEIVED VISION AND HEARING TESTS AND DENTAL CHECK-UPS, AND THE NUMBER OF HANDICAPPED CHILDREN WHO RECEIVE REHABILITATIVE SERVICES. THESE ARE CHILDREN WHO WOULD NOT HAVE OTHERWISE RECEIVED THOSE SERVICES. THE BLOCK GRANT FUNDS SUPPORT A NETWORK OF CLINICS WHICH PROVIDE APPROXIMATELY 12 MILLION MOTHERS AND CHILDREN WITH HEALTH SERVICES.

PREVENTIVE AND PRIMARY HEALTH CARE SERVICES ARE COST-EFFECTIVE BECAUSE THEY REDUCE THE NEED FOR MORE COSTLY HEALTH SERVICES IN THE FUTURE. FOR EXAMPLE, ALABAMA OFFICIALS ESTIMATE THAT FOR EVERY DOLLAR SPENT ON PREVENTIVE MATERNAL AND CHILD HEALTH CARE THE STATE WILL SAVE BETWEEN $5 AND $10 ON LONG-TERM INSTITUTIONAL CARE FOR THE SEVERELY RETARDED. A GAO STUDY FOUND THAT THE COSTS OF SCREENING INFANTS AND THE TREATMENT OF SEVEN COMMON DISORDERS WERE LESS THAN ONE-EIGHTH THE COSTS OF CARING FOR AN IMPAIRED CHILD OVER A LIFETIME.

HOWEVER, WE SOMETIMES HAVE DIFFICULTY GRASPING THE CONCEPT BEHIND LONG-TERM COST-EFFECTIVE PROGRAMS LIKE MCH. THE BOTTOM LINE IS THAT THE COSTS ARE INCURRED NOW, AND THE SAVINGS ARE REALIZED LATER.

THE NEED FOR IMMEDIATE MEASURES TO REDUCE THE BUDGET DEFICIT MAY EXPLAIN IN PART THE TROUBLED HISTORY OF MCH PROGRAMS IN RECENT YEARS. DESPITE THE UNQUESTIONED VALUE AND IMPORTANCE OF THE MCH BLOCK GRANT, THE PROGRAM HAS BEEN CUT 33 PERCENT IN AUTHORIZATION LEVELS SINCE 1981. TRAGICALLY, THESE CUTBACKS HAVE OCCURRED DURING A PERIOD OF INCREASED DEMAND FOR SERVICES. THE RECENT RECESSION HAS MEANT NOT ONLY THE LOSS OF JOBS, BUT ALSO THE LOSS OF HEALTH INSURANCE COVERAGE. FOR INCREASING NUMBERS OF CHILDREN, THE PROGRAMS FUNDED BY THE MCH BLOCK GRANT ARE THEIR ONLY SOURCE FOR NEEDED HEALTH SERVICES.

LAST YEAR, THE MCH BLOCK GRANT RECEIVED AN ADDITIONAL $105 MILLION THROUGH THE SO-CALLED JOBS BILL. NOW, IT IS BEING ARGUED IN SOME QUARTERS THAT THERE IS NO LONGER ANY NEED TO MAINTAIN FUNDING AT A CONSTANT LEVEL. WE HEAR THAT THE ECONOMY

IS IN THE MIDST OF A RECOVERY, AND THAT AS A CONSEQUENCE, THE DEMAND FOR MATERNAL AND CHILD HEALTH SERVICES SHOULD HAVE DECREASED. BUT THIS ARGUMENT IS SPECIOUS. THE JOBS BILL MONEY ENABLED STATES TO RESTORE CUTBACKS IN SERVICES BROUGHT ABOUT BY BUDGET CUTS OF PREVIOUS YEARS. BUT THE FUNDS WERE INSUFFICIENT TO EXPAND OR INCREASE SERVICES TO MEET THE INCREASED DEMAND FOR SERVICES. INDEED, A 1980 GAO STUDY INDICATED THAT EVEN BEFORE THE CUTBACKS WERE MADE INSUFFICIENT FUNDS PRECLUDED MANY STATES FROM OFFERING SERVICES TO ALL MOTHERS AND CHILDREN WHO NEEDED THEM. STATES HAVE TARGETED THE JOBS BILL FUNDS FOR PROJECTS IN AREAS OF HIGH NEED AND HIGH UNEMPLOYMENT. IN ARKANSAS, THE JOBS BILL MONEY WAS USED TO PROVIDE PRENATAL CARE IN A 13 COUNTY AREA WHERE PREVIOUSLY PREGNANT WOMEN HAD NO PLACE TO GO. THE RECOVERY OF THE ECONOMY WILL DO NOTHING TO REPLACE THIS SERVICE. IN FACT, THERE ARE STILL 22 COUNTIES IN ARKANSAS WHERE PRENATAL SERVICES ARE NOT AVAILABLE.

IT IS TRAGIC THAT THESE FIGURES, AND OTHERS LIKE THEM FROM PRACTICALLY EVERY STATE ACROSS THE COUNTRY, FAIL TO MOVE

THIS ADMINISTRATION. IN PULASKI COUNTY, ARKANSAS, ONE-HALF OF THE PREGNANT WOMEN WHO COME TO THE MATERNITY CLINIC FOR SERVICES ARE TURNED AWAY, AND THOSE WHO RECEIVE CARE HAVE TO WAIT FIVE WEEKS TO SEE A PHYSICIAN. THERE ARE EIGHT COUNTIES IN ARKANSAS WITHOUT CHILD HEALTH CLINICS, LEAVING 45,000 CHILDREN BELOW THE AGE OF 18 WITHOUT SERVICES.

WE HAVE HEARD THAT BLOCK GRANTS RESULT IN A MORE EFFICIENT ADMINISTRATION OF EACH STATE'S HEALTH SERVICES AND ALLOW FOR THE MORE EFFECTIVE DELIVERY OF SERVICES. BUT THE PROJECTED SAVINGS DO NOT BEGIN TO OFFSET THE SEVERE CUTS IN FUNDING. IN ARKANSAS THE CUTS IN MCH FUNDS CAME ON TOP OF STATE CUTS WHICH RESULTED IN 130 EMPLOYEES LOSING THEIR JOBS.

WE HAVE HEARD THAT MCH IS A STATE AND LOCAL ISSUE, THAT FEDERAL INITIATIVES ARE INAPPROPRIATE, INEFFICIENT, AND INEFFECTIVE. BUT WE KNOW THAT MCH PROGRAMS HAVE HAD A LONG AND DISTINGUISHED FEDERAL HISTORY, BEGINNING IN 1935 WITH TITLE V UNDER THE SOCIAL SECURITY ACT. FURTHERMORE, AT A TIME WHEN

THE STATES ARE STRUGGLING TO COPE WITH MEDICAID CUTBACKS IN ELIGIBILITY, BENEFITS AND PAYMENT LEVELS, THEY ARE FINANCIALLY UNABLE TO INCUR GREATER RESPONSIBILITY FOR MCH PROGRAMS. IN ARKANSAS, ONE OUT OF EVERY FOUR CHILDREN LIVES IN POVERTY, YET 60 PERCENT OF THOSE CHILDREN ARE INELIGIBLE FOR MEDICAID. IN ARKANSAS, STATE AGENCIES ABSORBED $400,000 OF THE $700,000 THE STATE LOST DUE TO THE CUTS IN MCH. THEY CANNOT OFFSET ANY FURTHER CUTS.

WHY DO WE PUT STATES IN THE POSITION OF HAVING TO CHOOSE BETWEEN FUNDING CHILD HEALTH CLINICS OR MATERNITY CLINICS? WE ASK STATES TO DECIDE WHICH IS MORE IMPORTANT, WHAT HAS THE GREATEST RETURN ON THE DOLLAR: SUDDEN INFANT DEATH PROGRAMS OR FLUORIDATION TREATMENT PROGRAMS. AT LEAST THESE ARE QUESTIONS WE'VE HAD TO RESOLVE IN ARKANSAS.

WHAT KIND OF A GOVERNMENT WOULD ASK A STATE TO DECIDE WHICH OF A CHILD'S HEALTH NEEDS ARE MOST IMPORTANT?

CLEARLY, THIS ADMINISTRATION HAS SET ITS PRIORITIES. WHEN THE ADMINISTRATION LOOKED FOR BUDGET DEFICIT REDUCING

MEASURES, IT TURNED TO FURTHER CUTS IN PROGRAMS LIKE MCH.

IT IS TIME FOR CONGRESS TO DEFINE OUR PRIORITIES, AND TO CONTINUE PROGRAMS THAT WE BELIEVE ARE JUST, FAIR AND COST-EFFECTIVE. IF WE FAIL TO ACT NOW TO PRESERVE THE INTEGRITY OF THESE PROGRAMS, WE WILL ONLY BEAR GREATER COSTS LATER.

I HAVE INTRODUCED A BILL TO INCREASE THE LEVEL OF FUNDING AUTHORIZED FOR THE MCH BLOCK GRANT. IT WOULD INCREASE THE AUTHORIZATION LEVEL FROM $373 MILLION TO $499.5 MILLION. THAT IS THE MINIMUM NECESSARY TO ENSURE THE CURRENT LEVEL OF SERVICES FOR FY 1984. MCH IS THE ONLY HEALTH CARE PROGRAM EXPLICITLY FOR CHILDREN. THE IMPACT OF THE CUTS HAS BEEN DEVASTATING. SELDOM DO WE SEE SUCH STARK AND TERRIBLE RESULTS FROM OUR IMPRUDENT ACTIONS.

Senator BENTSEN. Thank you very much for being here.

As Senator Bumpers has stated, the MCH block grant programs have been cut 33 percent between 1981 and 1984. The impact has been very substantial with numerous indicators of maternal and child health care turning down for the first time in decades. The incidence of low birth-weight babies is on the rise now, as well, in States that are as varied as Utah and New Hampshire.

And data just released this morning to the committee by the Food Research and Action Center shows that at least nine States have experienced a complete reversal in infant death trends. In those nine States, infant mortality statistics and the number of infant deaths rose in 1982 for the first time in years.

As we see on this attached chart over here, rising infant mortality is not concentrated in any one region. Three of the States with rising infant mortality rates are in New England. Three are in the South. And three are in the West. And this list will surely grow as data flows in from the 15 States still compiling statistics.

There is no doubt in my mind that the 1982 reduction in Federal child and maternal health care funding has played a very major role in the rising tide since then of needless infant deaths.

That tragedy has been magnified by our economic downturn—the worst recession since the 1930's—which has thrown millions of men and women out of work and off the health insurance rolls. These men and women and their families have been forced to rely on our publicly funded health infrastructure at the precise time that infrastructure was being reduced by Washington.

If there ever was a wrong time and a wrong place to reduce access to medical care or maternal health care, it was in the midst of this worst post-war recession. We began to pay the price for that in 1982. And, many infants and families will be paying a very heavy financial and emotional price for a generation to come.

Our Nation does a poor job of collecting medical data. And the magnitude of the impact of the MCH block grant cuts in 1982 is only just now beginning to trickle in. The infant mortality data that we have released here today has just been compiled and are only available for 35 States so far. They reveal that our Nation's proud advance toward improved infant health has stalled and may well have turned into a retreat.

But these numbers disguise the real tragedy of needless handicapped and dying infants.

It is difficult to deal with this topic without some emotion. But this Congress just has to do that. We must look beyond those numbers to learn exactly what the impact of the 1982 MCH block grant cuts have been. And to do that, we have assembled a very distinguished group of medical experts from across this Nation.

Ms. Gloria Smith is the director of Michigan's Health Department, a State that was hit doubly hard by program cuts and the recession. Ms. Smith is releasing a report here this morning on the impact of the MCH program cuts and steps being taken in Michigan to improve child and maternal health care. She is going to be joined by Ms. Sara Rosenbaum of the Children's Defense Fund here in Washington, by Dr. Richard Nelson from the University of Minnesota and Gillette Children's Hospital, by Dr. Kenneth Osgood of Las Vegas, N. Mex., who is appearing on behalf of the American Academy of Pediatrics, by

Dr. Arthur Salisbury, vice president of the March of Dimes, and by Ms. Josephine Gittler of the University of Iowa, and codirector of the National Maternal and Child Health Care Center.

I am pleased to welcome each of you. Would you please come forward and take your positions.

[Pause.]

Senator BENTSEN. I am going to ask each of you to please hold your initial statement to 5 minutes. We will place your full statements in the record and then we will go to questions.

I would like to call on Ms. Rosenbaum first.

STATEMENT OF SARA ROSENBAUM, DIRECTOR, CHILD HEALTH DIVISION, CHILDREN'S DEFENSE FUND, WASHINGTON, D.C.

Ms. ROSENBAUM. We are in the process at the Children's Defense Fund of analyzing 5 years of natality statistics from all 50 States. Although our data are still being compiled, I have brought with me this morning certain data from the State of Texas concerning births by place of residence and by race. I have copies that can be distributed now.

Senator BENTSEN. Fine.

Ms. ROSENBAUM. These data show the time at which prenatal care was begun by race among women from 1978 to 1982. What we are finding in Texas as well as in a number of States around the country is that whether one examines women in prenatal care by total count or by race, there is a rise in the number of women who are delivering babies with late or no prenatal care. As a national average, the percentage of white women having babies who experience late or no prenatal care is roughly around 5 percent. The figures for minority women are about double that, or about 10 percent. For Hispanic women, we find that as a national average, the figure hovers around 12 percent receiving late or no prenatal care.

Senator BENTSEN. Ms. Rosenbaum, I am told a rather shocking number and I want to know if it is accurate. I am told that Houston has a higher infant mortality rate than Honduras. Can that be true?

Ms. ROSENBAUM. I believe that there are either portions of the city or the city as a whole, as is the case in Detroit, as I think Ms. Smith will mention, where the infant mortality rate runs many, many times over the normal rate for the State, over the rate for the Nation as a whole and approaches levels that one would find in less-developed countries.

One of the major problems, with the way in which the Reagan administration has attempted to report infant mortality data is that it looks at national statistics. It counts into the same statistics women giving birth who are affluent and low-risk patients with women in extremely high-risk situations. And so, although national infant mortality rates are steadily declining, we find that when one begins to look at certain areas of the country or at certain racial and ethnic groups who tends to be poorer and more disenfranchised, that the death rates are quite startling.

One of the figures that we looked at, aside from the actual birth outcome, was the percentage of women receiving early prenatal care, since there is such a close association, as Doctors Eaton and Budetti

testified, between prenatal care and birth outcome. And what we are finding is that for black women, for Hispanic women, white women, the rate in Texas of women going without prenatal care has steadily climbed and for each category now is well over the national average.

The rate as of 1982 for black women was 12.4 percent receiving late no prenatal care, for Hispanic women, 16.2 percent receiving late no prenatal care, and for white non-Spanish speaking women, 6.1 percent.

These are alarming statistics and these are statistics that we are seeing in other areas of the country as well, as a report to be issued in January will show.

I thought you would be interested in one particular anecdote from Texas that came to me last week. A physician called me from Temple, Tex. He practices at Scott and White Hospital in Temple, Tex. He called to find out what was happening with Federal budget cuts. And we began to talk. He is a neonatologist in Temple, Tex. And he told me that they have seen a sixfold increase over the past year in the number of high-risk infants who are being transferred to Scott and White at distances of up to about 200 miles, which is a horribly dangerous transfer distance. This is happening because if babies being born now in Houston and other areas, who have no insurance or no means of paying for the care, cannot find a bed.

On top of that, transport systems are beginning to lose funds so that hospitals that will accept these babies are having a difficult time finding transport systems that will go long distances.

So not only are these babies being transported long distances, but there are delays of up to 12 hours in transporting them, which puts them at even greater risk. And this is just from one hospital in one part of Texas. We have heard stories like this from many, many States.

[The prepared statement of Ms. Rosenbaum follows:]

Prepared Statement of Sara Rosenbaum

Good morning. I am Sara Rosenbaum, Director of Child Health at the Children's Defense Fund. The Children's Defense Fund (CDF) is a national public charity created to provide long range and systemmatic advocacy on the major issues affecting America's children. Our goal is to ensure that all of our children are given the opportunity to lead healthy and productive lives, free of the "badges" of disadvantage that plague so many of them today.

Ill health is intimately associated with poverty.[1] Furthermore, it has a prolonged and serious impact on poor children's efforts to rise above poverty. Poor health can virtually ensure the continuation of impoverished status as sick children grow up and attempt to compete in an adult world. CDF has therefore spent over a decade trying to ensure that access to health care by poor women and children in America is based solely on their need for care.

I am particularly pleased to be here today, Senator Bentsen, because of your demonstrated commitment to the issue of better health care for children in America. Your leadership has been absolutely crucial to the effort to improve the performance of our most basic federal health programs for mothers and children. As you know, working on these issues can be a somewhat lonely task. I am sure that very few of the people directly affected by your efforts on behalf of federal maternal and child programs will be able to personally express their thanks. Indeed, the mothers and children whom you are assisting are nearly invisible in our society. For many it has been all too easy to forget their ongoing needs entirely in the crush of other business.

We at CDF look forward to the day when we can testify at a Congressional hearing that the nation has remedied the basic inequities in its health care system. Unfortunately, however, we have not yet dealt adequate

with the most fundamental problems of access to health care that daily confront millions of poor mothers and children in need of services.

By the beginning of this decade, as Drs. Eaton and Budetti testified earlier, we had made substantial progress in opening the doors of the health care system to millions of impoverished families. By the end of the 1970's poor children averaged 65% more physician visits than in 1964[2], and infant mortality rates dropped by over 40% between 1967 and 1979.[3] Numerous researchers have concluded that federal health programs have resulted in improved access to health services by the poor and have played a key role in bettering the survival rate of infants and improving poor children's health status.[4]

Yet, it is also evident that serious inequities remain:

- One in every 20 women receives no prenatal care until the last trimester, while one in 76 receives none at all. 5/ One out of every 11 pregnant Black women receives no prenatal care until the last trimester, while one in 37 receives none at all. 6/ Twelve percent of all Hispanic women giving birth in 1980 did not receive care until the third trimester or received none at all. 7/

- A recent study funded by the Robert Wood Johnson Foundation found that, not only were perinatal mortality rates 4-12 times higher among women delivering babies who had received little or no prenatal care, but that at least 25% of these women had actually sought the care but had been turned away for lack of ability to pay. 8/

- Low birthweight, one of the factors most closely associated with infant mortality and the presence of permanent handicapping conditions, continues to be a major problem in the United States. America ranks second among 9 other industrialized nations in the percentage of births that are low birthweight. 9/ The incidence of low birthweight births, like the mortality rate, is twice as high among Black infants. 10/

- Among children in America living at or below the federal poverty level -- now one out of every 5 -- over 50% have not seen a dentist in the past two years. 11/ Dental disease, a permanent crippler, strikes over 95% of all children age three and over. 12/ Yet nearly 10% of poor children have not seen a physician in the past two years. 13/

- In 32 states, there is no Medicaid coverage for pregnant women living in two-parent working families, no matter how poor they are. 14/

- In 26 states, pregnant women and children in two-parent unemployed families are unable to qualify for Medicaid no matter how poor they are. 15/

- In 6 states, single women, no matter how poor, cannot get Medicaid until their child is born, thereby making prenatal care a near impossibility. 16/

- In 28 states, children in two-parent working families cannot get Medicaid coverage, no matter how poor the families or how sick the children. 17/

- By 1980, Medicaid reached fewer than half of all families living in poverty. 18/ Moreover, while only about 20% of children in upper income families fail to receive any physician care in a year, 19/ a recent national study has estimated that about 70% of all Medicaid-enrolled children, who are, by definition, sicker as a result of their impoverishment, 20/ fail to receive any service under Medicaid during a year. 21/ In Fiscal Year 1981, the Title V Maternal and Child Health Programs reported serving only about 350,000 mothers and children with primary and prenatal maternity care. 22/ We estimate that because of the shortcomings of these programs, millions of indigent mothers and children have no identifiable source from which to obtain needed health care.

It is thus evident that in 1980 there were serious shortcomings in our federal health care programs for mothers and children. A suggestion of what becomes of families who "fall between the cracks" of these federal health interventions is provided in a recent study of the relationship between possessing health insurance and using health care. The study revealed that: insured persons used 54% more physician services than their uninsured counterparts; even more startling, the uninsured used 90% more hospital care than did the uninsured.[23] Yet, because of the inadequacies of

public financing programs for children, nearly 50% of poor children are either always uninsured or insured for only part of the year.[24] This means that about 6.6 million poor children are now facing the significant barriers to needed health care as a result of their uninsured status.

It is against this programmatic backdrop that the Reagan Administration and its supporters succeeded in 1981 in gaining significant reductions in federal health programs as recession and unemployment were simultaneously creating an ever-larger pool of impoverished families dependent on increasingly fewer resources. Medicaid was reduced by over $4 billion. The Title V program was reduced by about 20%. The Community Health Centers program, another key federal program for mothers and children was reduced in funding by about 25 percent.

Because mothers and children depend so heavily on federally funded health clinics, and because, as Dr. Budetti noted, children are disproportionately dependent on the Medicaid program as their major source of public health funding, we believed that it was important for us to attempt to assess federal budget reductions' impact on health programs for mothers and children. Our findings, reported fully in Children and Federal Health Care Cuts, a copy of which I would like to submit for the record, were deeply disturbing. As of the end of 1982:

- After an intensive effort in Alabama to decrease infant mortality, officials reported that the state's infant death rate was back at the 1980 level when Alabama had the highest infant mortality rate in the nation.

- In Ohio over 700,000 people were out of work. The state health department estimated that over one million Ohioans had no health insurance. Potentially, in the next three years alone, 60,000 children will be born to Ohio parents who have lost health insurance due to unemployment or underemployment. A preliminary look at seven Ohio counties revealed that as unemployment increased do did infant mortality. In the county that includes Youngstown, where unemployment was 18.6 percent, the infant mortality rate increased from 13.7 percent to 14.9 percent between 1980 and 1981.

- In some parts of Detroit, the infant death rate hit 33 per 1,000 live births, the same death rate as Honduras, the poorest country in Central America. (Inadequate prenatal care contributes to infant mortality. One percent of all mothers who gave birth in 1979 in Detroit -- 386 women -- did not see a doctor until the day of their delivery. Among these women, the infant mortality rate was 88 percent.) Warren, Michigan, saw a 53 percent increase in its infant mortality rate; Pontiac, a 17 percent increase, and Flint , a 12 percent increase. Poor economic conditions, high unemployment, and unprecedented reductions in public health services contributed to these increases.

- Almost 700,000 children lost Medicaid coverage because of the cuts in the AFDC cash assistance program made in 1981 by Congress at the Reagan Administration's request. Additionally, some states made deeper Medicaid cuts than Congress required in the 1981 budget bill.

- Officials who have analyzed Medicaid eligibility trends in their state during 1982 uniformly report that the overriding cause of lost Medicaid eligibility was the restrictions placed on the AFDC program under the Omnibus Budget Reconciliation Act of 1981 (OBRA). Loss of AFDC also means loss of Medicaid. Since almost 70 percent of all AFDC recipients are children, they have borne the brunt of the Medicaid eligibility cuts emanating from federal welfare reductions.

- In addition to AFDC-caused reductions in Medicaid eligibility, 17 states (Alabama, California, Delaware, Florida, Georgia, Hawaii, Kansas, Michigan, Mississippi, Missouri, Montana, North Carolina, Oregon, Rhode Island, South Carolina, Virginia, and Washington) cut Medicaid more than rquired by federal AFDC cuts, to the detriment of children. Specifically, 13 states (Alabama, Delaware, Florida, Georgia, Hawaii, Kansas, Mississippi Montana, North Carolina, Oregon, Rhode Island, South Carolina, and Virginia) have eliminated coverage for some or all categories of children between the ages of 18 and 21. Five states (California, Kansas, Michigan, Missouri, and Virginia) have tightened financial eligibility criteria. Four states (Montana, Utah, Missouri, and Washington) eliminated benefits for two-parent uemployed families.

- Many states reported significant increases in Medicaid caseloads because of unemployment. Some of these same states had to make the severest health care cuts, despite the number of "new poor families" in need of health services, because of economic conditions.

- During the second half of 1982, 21 states reported experiencing increases in their Medicaid caseloads. In 16 of the states (Arkansas, California, Illinois, Iowa, Kansas, Maine, Maryland, Michigan, Nevada, New York, Ohio, Pennsylvania, South Dakota, Utah, West Virginia, and Wisconsin), officials reported that these increases were caused by unemployment.

- In Michigan, where unemployment was at depression levels, the state has been forced to make deep cuts in public maternal and child health programs at the very time that the demand for public health services is surging. Eligibility criteria for Medicaid benefits were reduced, making it more difficult for poor families to qualify for aid. The state also closed three public health clinics serving 6,000 pregnant women and 11,000 children, and two Family Planning Projects which had served 58,500 women. The state predicts 9,700 unanticipated pregnancies will result from the unavailability of Family Planning Services. Additionally, five Community Health Centers have been cut, affecting some 15,000 patients statewide.

- Utah, Montana, Washington, and Missouri eliminated their AFDC programs for two-parent unemployed families, which also would have provided these uninsured families with Medicaid benefits.

- Wyoming and Missouri officials reported that they were seeing two-parent families split up in order to qualify for the assistance available only to single-parent families.

- Just when health care cost containment was critically needed, cost-effective prenatal and delivery services for pregnant women and primary and preventive services for infants and children were forced to bear the brunt of Title V Maternal and Child Health Block Grant cutbacks. Forty-four states (93 percent of those reporting reductions in their Title V programs) reduced prenatal and delivery services for pregnant women and primary and preventive services for women of child-bearing age, infants, and children. Twenty-seven states (57 percent) reduced their Crippled Children's Services. Thirty-seven states (82 percent of those reporting Title V reductions) reduced or eliminated services offered by the Title V programs of projects. Children and Youth Projects were the most frequently affected.

- Thirty-one states reduced or eliminated Medicaid services important for mothers and children, including new limitations on hospital, physician, clinic, and prescribed drug services.

In short, the picture for poor mothers and children was alarming in 1982. Despite a somewhat less severe economic situation now, and some vital supplementation of Fiscal 1983 expenditures for such programs as the Title V Maternal and Child Health Block Grant, the bleak picture continues:

- recently released data reveal that 40% of children ages one to 4 are still not immunized against childhood disease. Ten percent fewer preschoolders received their Diptheria-Tetanus-Pertussis shots in 1982 than in 1970. Nonwhite preschool children, moreover, are far less likely to be immunized than are white children. Half have not received DTP shots, while more than 60% have not been immunized against polio. 25/

- There is evidence that migrant children are particulary under-immunized. For example, from January 1 through April 27, 1983, a total of 93 clinical measles cases were reported in Florida. Eighty-seven of these (93.5%) occurred among migrant workers and their dependents. Twenty-one of these 87 cases occurred in migrant worker camps. This outbreak occurred principally among preschoolers. Seventy-one of the 87 cases (76.3%) involved children under 5 years old. During the first eight weeks of the outbreak, 36 of these children had otitis media and 3 (8.3%) had pneumonia. The highest complication rate occurred in infants under 15 months old. Of the infants who were affected, nearly 15% developed otitis and over 9% had pneumonia. 26/

- During this past summer, we did a more specific survey of how the Title V-funded maternity projects described by Dr. Eaton were faring in 1983. We looked at Maternity and Infant Care (MIC) projects because, as Dr. Eaton so eloquently testified, these particular Title V-funded projects have had a dramatic impact on infant mortality in the communities they serve. We found that, uniformly, funding for these projects has been drastically cut and that the funding cuts have forced the projects to curtail services or further restrict eligibility requirements. Because these projects are by definition located in seriously

underserved areas and offer a unique type of care, the result of curtailing these projects has been that many women are reportedly going without care.

- Our interviews with the MIC project personnel are confirmed by evidence from numerous states showing that an increasing number of women are now going without prenatal care until late in their pregnancy or are receiving none at all. Studies from Oregon, 27/ Kentucky, 28 / and New York 29/ all report an increase in the incidence of women receiving little or no prenatal care. In Kentucky, one of the states reporting an increase in the percentage of women receiving little or no prenatal care, the MIC project contacted in our survey was forced to turn away 103 women during one month alone. A spot investigation of 11 of these women revealed that 7 went without care completely. Of the four who did obtain care, one had seen a physician only once and was in her third trimester.

The cost to the nation of our current national maternal and child health "policy" is, of course, incalculable in human terms. As Drs. Budetti and Eaton testified, the nation will pay a terrible price for its failure to make maternity and pediatric care universally available to those who need it.

But in budgetary terms, the policy is just as irrational. A recent study estimates that the federal government loses a half billion dollars a year in Medicaid funds to infant mortality and handicapping.[30] The average cost to the Medicaid program for complete maternity care has been estimated by the Congressional Budget Office to be $1400 per expectant mother.[31] Routine health services for children are estimated to cost about $600 per year.[32] Providing care to sick and damaged babies during just the first year of life has been shown to outweigh the cost of providing adequat maternity care.[33] States that have tried to estimate the cost of a life-time of care for these babies have found that they are losing millions of dollars annually by failing to provide adequate prenatal care.[34]

It is obvious that the time has come to stop making cuts in programs that secure access to maternal and child health care, including Aid to Families with Dependent Children, Medicaid, Title V, and other public health programs. Far more than that, however, for the societal and financial health of this nation, the time has come to start putting money into these programs. The availability of Medicaid should not depend on whether one or two parents are present. Health insurance should not be available, as in Texas, for example, only to those mothers and children whose annual income does not exceed approximately $1800 for a family of four. Funding must be available to ensure that every community in this nation has adequate maternity, newborn and pediatric services for those who need them. Where there are insufficient private providers to furnish such care, public programs such as the Title V Maternal and Child Health Block Grant must be funded at reasonable enough levels to be able to respond to the need for publicly-provided care.

We look forward to working with you to accomplish what is so right and necessary for our children. Thank you.

Footnotes

[1]See, e.g., Starfield, Barbara, "Poverty, Illness and Childhood" (Keynote address for the Conference on Childhood Deaths, Augusta, ME, June 30, 1983), Johns Hopkins School of Hygiene and Public Health.

[2]Brown, E. Richard, "Medicare and Medicaid: The Process, Value and Limits of Health Care Reforms," Journal of Public Health Policy 335, 348 (Sept, 1983).

[3]Congressional Research Service, Infant Mortality, (June, 1983) at p. 9 (Committee Print 98-J)

[4]See, e.g., Hadley, Jack, More Medical Care, Better Health (Urban Institute, Wash, DC, 1982), which among other things, found a correlation between neonatal mortality rates and state Medicaid policies for coverage of pregnant women.

[5]Data from National Center for Health Statistics (1980).

[6]Ibid.

[7]National Center for Health Statistics, Births of Hispanic Heritage, 1980.

[8]Chou, Solan, et al, Reasons for Absence of Prenatal Care and Its Consequences (Harlem Hosp. Ctr, NY, NY 1982)

[9]University of North Carolina School of Public Health, Child Health Outcome Indicators (May, 1983).

[10]Ibid.

[11]Data from National Center for Health Statistics (1980).

[12]United States Department of Health and Human Services, Preamble to issuance of final rules for the Medicaid Early and Periodic Screening Diagnostic and Treatment Program, May 18, 1979. (44 Fed. Reg. 29420)

[13]National Center for Health Statistics, op. cit.

[14]H. Rep. 98-442, to Accompany HR 4136, The Medicare and Medicaid Budget Reconciliation Amendments of 1983, at p. 44.

[15]Ibid.

[16]Ibid.

[17]Ibid.

[18]Wilensky, Gail, "Health Care for the Poor and the Role of Medicaid." Health Affairs (Fall, 1982).

[19]National Center for Health Statistics, (1980).

[20]See note 1, supra

[21]Data from the National Medicaid Quality Control Data Set (Study release pending). Children eligible for Medicaid tend to live in extreme levels of impoverishment -- far more severe than that encountered by the elderly, for example, as a result of the failure of the AFDC program to keep pace with inflation. Budetti, Peter, et al, "Federal Health Program Reforms: Implications for Child Health Care," 60 Milbank Memorial Fund 155 156 (1982). Thus, it is unlikely that these children (for example, the incremental monthly AFDC income of a mother and 2 children is about $35 a piece in Mississippi) would purchase services other than with their Medicaid cards.

[22]Association of State and Territorial Health Officials, Comprehensive Report on State Title V Programs (1981).

[23]Davis, Karen and Rowland, Diane, "Uninsured and Underserved", Securing Access to Health Care, Vol II (President's Commission on Medical Ethics, Wash, DC, 1983)

[24]Wilensky, op. cit.

[25]National Center for Health Statistics, current immunization data.

[26]Center for Disease Control, 32 MMWR 471 (Sept 16, 1983).

[27]M. Curry, Trends in Prenatal Care for Oregon Births (1983, Or, Health Department).

[28]Kentucky Coalition for Maternal and Child Health, Healthy Mothers and Babies: Pay Now or Pay Later (1983).

[29]Lukomnik, Joanne, MD, Montifiore Hospital (1983).

[30]Black Women's National Health Network v. Heckler, filed, June, 1983.

[31]H. Rep. 98-442, op cit.

[32]Ibid.

[33]Black Women's Health, op. cit.

[34]For example, the state of Virginia estimates that, because of longterm care, the cost to its Medicaid budget of not providing comprehensive maternity and newborn care is $49 million annually. Va. Prenatal Care Advisory Committee, 1983 Report to the State Legislature (Richmond).

Senator BENTSEN. Ms. Smith, please proceed.

STATEMENT OF GLORIA R. SMITH, DIRECTOR, MICHIGAN DEPARTMENT OF PUBLIC HEALTH, LANSING, MICH.

Ms. SMITH. Thank you, Mr. Chairman, I would underscore the fact that although the national infant mortality rate is going down and that people are looking at that and taking comfort in it, many of our cities, like Detroit, are not on the graph at all. This chart [indicating] shows the observed and the predicted infant mortality rates, and we can see that the overall trend is downward. But if you look above, that orange line [indicating], that is the city of Detroit. Its rates are so high that it is not on this graph at all.

We are still having infant mortality rates in Detroit that are equivalent to those in developing countries and we can identify the census tracts where that takes place. This occurs not only in large urban cities, but also in smaller communities. In areas where there are culturally diverse populations, where we are not able to match early identification of pregnancy and early prenatal care with the patient, we run into difficulty. We need to get patients to these services earlier.

There are large groups of women in Michigan who do not receive adequate prenatal care at this time. In 1981, there were almost 9,000 who had five or less prenatal visits. And of this group, almost 1,000 had had no prenatal care at all.

Infant deaths in this group range from 60 to 80 infant deaths per 1,000 live births. So you can see how important it is to have prenatal care and to have it early enough and to have a full range of services so that we can save these children's lives.

With the unemployment situation in our State, there is no question that there is a correlation between the high unemployment and the access to maternity care. We are coping with this as best we can and, of course, the infusion of dollars last year through the jobs bill made our lives much easier and it made it possible for us to provide needed services.

We feel that the funding cuts that have crippled America's maternal and child health program should be immediately restored and the MCH block grant should be doubled by fiscal year 1984–85. We feel quite strongly about this.

We also believe that a new unit for children, youth, and families should be established at a high level within the U.S. Public Health Service.

Third, an emergency maternity and infant care service should be developed and piloted for the uninsured woman and her infant to age 18 months. If we are to reduce infant deaths and promote the health of women in our country, we must provide on an interim basis emergency comprehensive maternity care. This would be aimed at the recently unemployed and provide family planning, prenatal care, labor, delivery and post-partum care, pediatric care for the infants to 18 months of age and health education.

And finally, it is recommended that a national children's trust fund be established to develop innovative approaches for promoting the health and welfare of children, youth, and families.

Mr. Chairman, thank you for the opportunity to appear before the Joint Economic Committee today to provide you with information about the many needs of mothers and children in Michigan.

I would request that my brief remarks, together with both our shortened and full report entitled "Safeguarding the Health of Mothers and Children," be entered into the record of these important hearings.

[The prepared statement of Ms. Smith, along with the report referred to, follows:]

Prepared Statement of Gloria R. Smith

Mr. Chairman, thank you for the opportunity to appear before the Joint Economic Committee today to provide you with information about the many needs of mothers and children in Michigan.

I would request that my brief remarks, together with our full report entitled Safeguarding the Health of Mothers and Children, be entered into the record of these important hearings.

Health promotion and disease prevention programs for mothers and children have been organized principally in response to national leadership since the creation of the original U.S. Children's Bureau in 1912 and the passage of the Sheppard-Towner Act in 1921.

These programs and services have always had as their basis two important tenets.

First, improvement of the health of mothers and children is an important corridor to better health for the entire population. Mothers and children constitute a highly strategic group; they are especially vulnerable to hazards and attendant problems of reproduction, growth and development and at the same time are the segment of the population which is most responsive to health care.

Secondly, the health of mothers and children is closely related to the general health of the community and to the social, economic and cultural background of the country as a whole. Measures which improve the general public health will also benefit mothers and children.

It is my belief that national leadership is also needed today. Is America any less concerned for its children than it was over seventy years ago?

It is the purpose of this brief testimony to: reveal the tragic impact of high unemployment rates on the health of mothers and children in Michigan; discuss current and future economic prospects for our state; review unmet needs; demonstrate that prevention strategies will contain health care costs; and set forth recommendations for consideration by the Joint Economic Committee.

In January 1983, the Michigan Department of Public Health conducted an intensive review of the impact of unemployment on the health of our mothers and children. The results were startling. We found that a human emergency existed and that Michigan was in the worst economic condition of any state in the Nation. We were in the 37th consecutive month of double digit unemployment, with more than 740,000 people out of work. This is a larger number of individuals than the entire population of many states in the union.

About 20,000 workers were exhausting their regular unemployment benefits every month and well over 100,000 had exhausted their extended benefit period. The number of persons receiving some form of public assistance had increased 35 percent over the previous 48 months and 15 percent of our total population were receiving some form of public assistance.

Michigan's economic and human crisis had come at a time when the state

was least able to cushion the many tragedies which threatened family life.

Tax collections were down. The state treasury was $900 million in the red. Past bookkeeping practices had added another $800 million. After three years of state cuts, hiring freezes and program terminations, we were facing a new round of $225 million in reductions. Our Department had lost $24.2 million in the previous sixteen months and the Maternal and Child Health Program $6.7 million during the same period.

The reductions we had experienced in the maternal and child health block grant by January, 1983 made it impossible for us to shoulder all of the competing needs for service. Our State fund reductions were every bit as bad, if not worse, than the federal cuts.

Thus, services were being reduced at a time when demand from the unemployed and the medically indigent were increasing exponentially.

Blue Cross and Blue Shield of Michigan reported a drop of 556,633 participants since 1979. Medicaid rolls had only increased by 106,000.

Michigan hospitals reported $142 million of unreimbursed care was given in 1982, up 29 percent from 1981. Some community hospitals were threatened with insolvency.

The economic downturn was the foundation of the picture seen in Michigan at that time of poverty, hunger, lack of access to health care and high infant mortality.

The infant mortality rate in Michigan had just been shown to have increased from 12.8 deaths per 1,000 live births in 1980 to 13.2 deaths in 1981. This increase represented a disturbing reversal of a 30-year trend which saw the infant mortality rate cut by 50 percent. Some areas of the state had realized a 100 percent increase in one year, and inner-city Detroit was one of the places where the problem became the worst.

Clearly the economic depression in Michigan, the state's fiscal situation and the unprecedented need and demand for human services were all extraordinary conditions. These were not unique to any particular area of the state. There were some families in critical need of basic food, clothing and shelter in nearly every community.

In January of 1983, Michigan elected a new Governor, James Blanchard. From the time he took office, Governor Blanchard moved forcefully to get Michigan moving again.

The first major hurdle to overcome was the state's insolvency. Governor Blanchard, together with the legislative leadership announced a combined program of budget cuts and state employee reductions with a state tax increase. The plan passed and it worked. Today, Michigan is reaping the benefits of a balanced budget and new confidence on Wall Street as debts incurred by the previous administration are paid off at an accelerated rate.

A constant and steady stream of economic development initiatives has come from Governor Blanchard. His 20-point plan includes such diverse elements as a summer youth jobs program which employed over 25,000 to retraining and education programs for the unemployed and a computerized technology network to let businesses tap the technological expertise of the five state universities.

Michigan is on the move and to characterize the Michigan of today as "empty smokestacks" and "bread lines of citizens" is incorrect. The auto industry after retooling its plants and introducing many new plans and technologies is showing record-breaking profits. This is a remarkable feat in the face of the previous 3½ year U.S. sales slump.

Of course, many problems remain. Michigan still has a double digit unemployment rate of 13.6 percent with 573,000 people jobless. With increased consumer spending forecast for this Christmas, we are hopeful of bringing these high rates down.

Final county of residence infant mortality figures for 1982 show that Michigan has resumed an encouraging downward trend in this important health status indicator. The 1982 infant mortality rate is 12.1 deaths per 1,000 live births. This compares to a rate of 13.2 for 1981.

The statewide improvement for 1982, however, does not extend to all subpopulations in Michigan. Black infants continue to die at over twice the rates of white infants and the gap actually worsened in 1982. It is also disturbing to note that while low birth weight ratios improved slightly for whites, they worsened for blacks. Also, more deliveries with no or low prenatal care occurred to blacks in 1982.

While overall the 1982 rate is down, Michigan has a higher level of infant mortality than expected had our improvements in the late 1970's continued. In effect, Michigan lost a few years of progress and an estimated 194 more infants than expected died during the two year period.

We have many unmet needs in Michigan among our mothers and children.

The Crippled Children's Program is included in the MCH Block Grant and is essential to handicapped children services in Michigan. The need and demand for this program's services has increased substantially.

High unemployment in Michigan continues to increase the number of residents receiving support for medical care and treatment. During the

recent years of recession, the number served by CC rose from 12,800 in FY 1980 to 14,000 in FY 1983. We also know there are many children with unmet needs not being reached.

The medical care and treatment services supported by this program are mainly specialty care services for certain severe conditions. Expenditures have increased from $16.26 million in FY 1980 to $23.02 million in FY 1983. Inflation has been the major cause of this rise which includes a $3.8 million increase in just the last year.

The MCH Block Grant also includes funds for the Supplemental Security Income/Disabled Children's Program. Its purpose is to provide case management service to individual multidisabled children approved by the Social Security Administration. We know from experience gained from delivering these services that they greatly improve the effectiveness and efficiency of response by extending resources to these children and their families. Yet, the program is only serving children from birth to 7 years of age while those up to 16 years of age are eligible, and we are trying to expand the services from thirty-five counties now served to all eighty-three counties in the state.

Our full report also documents the increasing requests for maternal and child health services such as prenatal care, infant and pediatric care and family planning. Our Department conducted an intensive survey of 48 local health departments in the spring of 1983 and found that there were:

> "....significant increases in categorical program demand and services provided throughout Michigan and most of this increase seems to have come from the "new poor"--i.e., persons who have assets, but no cash due to recent unemployment."

Increased waiting times and inability to expand clinic services due to lack of funds were common findings from the study.

The "Jobs Bill" which passed the Congress last Spring gave the Michigan Public Health system a badly needed infusion of roughly $11 million, nearly evenly divided between maternal and child health, WIC supplemental foods and community health centers. These funds were immediately programmed, and were out working in all local health departments in the state by mid-Summer. Let me share with you some of the impressive results.

Maternal - Child Health

An allocation formula based on need, using such variables as high unemployment and low birthweight rates was developed and for the first time MCH funds were given to all local health departments to establish service programs. These new activities include provision of prenatal care, health education and infant care to reduce high infant mortality. Badly needed school health and community nursing services were restored. Family planning services were expanded in several local health departments and accident prevention programs, like child auto restraint seats loan services were established.

WIC

The Michigan WIC Program had one of the largest expansions of any program in the nation. At risk and poor women, infants and children were enrolled through a coordinated and intensive state/local outreach

effort which saw the WIC caseload jump from 83,300 in April to 132,000 at the end of October. This vast increase of 58% attests to the serious health problems Michigan still faces. Even with the new caseload we are only able to serve about half of the women, infants and children believed to be eligible for nutrition supplements.

It is very important that the one-time funding be converted into permanent appropriations. This would enable us to continue the important work that has begun and allow us to start important new initiatives. Let me share just one of these with you.

There are large groups of women in Michigan who do not receive adequate prenatal care at this time. In 1981, there were 8,160 women who had five or less prenatal visits and of this group 930 were reported to have no prenatal care. Infant death rates in this group range in the 60-80 infant deaths per 1,000 live births, dramatically higher than those with the recommended standard of 12-14 visits. Low birth weight rates follow a similar trend, with those in the five or less prenatal visit group having three times the number of low birth weight infants as those in the average childbearing population.

If resources can be found, our Department will recommend that pre and postnatal care be expanded next October 1st and eventually designated as a "basic health service". This would mean that an important preventive service would be made available and accessible to all medically needy, pregnant women.

The greatest growth in health care costs have come from the entitlement programs, such as Medicaid. Cost effective programs which emphasize prevention and earmark funds to the most needy should not be reduced

since these programs have been able to provide services to increased numbers of persons and streamline costs during a period of high inflation. This is particularly true in periods of high unemployment and economic distress since the health of mothers and children is often the first to suffer.

Maternal and child health programs are cost effective. For example, federal government studies show that for every $1 spent on prenatal care, $4 to $6 are saved in neonatal intensive care (NICU) and re-hospitalization for low birthweight infants during the first year of life.

Also, a national study conducted by the Alan Guttmacher Institute demonstrated a benefit/cost ratio of $1.80 for every federal dollar invested in family planning.

In one sense society can "pay now or pay later" in the form of higher rates of disease, tertiary medical care, death and/or institutional maintenance of the severely damaged child.

As today's children grow into adulthood, they will have to perform increasingly complex tasks in an age of technological change to protect our natural environment, maintain our standard of living and keep our economy competitive with those of other nations. We must consider each of our children as a valuable national resource. Programs such as maternal and child health not only improve the health and enhance the lives of our children immediately, but also expand their potential for significant contribution to the nation as a whole.

The programs of the 1980's should be preventive in nature and based on a solid research base.

It is our contention that some shift in spending priorities must occur. The erosion of our industrial base together with the massive increase in joblessness has weakened our State and the Nation. At this time, as always, mothers and children are profoundly dependent on us for their well-being and we are proposing five actions to safeguard their health.

FUNDING CUTS THAT HAVE CRIPPLED AMERICA'S MATERNAL AND CHILD HEALTH SHOULD BE IMMEDIATELY RESTORED AND THE MCH BLOCK GRANT SHOULD BE DOUBLED BY FY 1984/85.

The maternal and child health block grant was formed by consolidating many related programs and cutting them approximately 25 percent. The cost of returning this program to previous funding levels, with inflation, would require new appropriations of about $110 million. This would put the Block grant at a level of $483 million.

It is further recommended that the MCH block be doubled in size to the $750 million to $800 million level in FY 1984/85. Such an investment will contain spiraling hospitalization costs for mothers and children and help ensure that our children will reach their maximum social and genetic potential.

The State and local health department system is in place. Services could be increased immediately as they were with the one-time federal Jobs money.

A NEW UNIT FOR CHILDREN, YOUTH AND FAMILIES SHOULD BE ESTABLISHED AT A HIGH LEVEL WITHIN THE UNITED STATES PUBLIC HEALTH SERVICE.

The major charge of this new unit of government should be:

"To investigate and report on the conditions affecting the health and welfare of America's children, youth and families."

It is essential that timely and accurate information be maintained on the health status of children, youth and families. This must also include accurate estimates of services rendered and the numbers of citizens in need of care who are not receiving such care. Such information is crucial for the President and the Congress as they discharge their duty to protect American family life.

Existing programs now operated by various branches of government should be realigned and many of them folded into the new administrative unit. Title X Family Planning and the Maternal and Child Health Block grant are two programs which should be transferred immediately.

There must also be strong program authority for coordination with other children's programs like EPSDT, WIC Supplemental Foods and Head Start.

FUNDING SHOULD BE RESTORED TO THE TITLE X FAMILY PLANNING PROGRAM.

In the United States almost all people, regardless of ethnic, religious or socio-economic background, wish to voluntarily choose the number and spacing of their children. Comprehensive family planning services represent an effective means of dealing with the health, social and economic problems associated at least in part with the occurrence of unwanted and mistimed pregnancies.

The family planning Title X program should be restored to its previous level of $162 million from the current reduced level of $141 million. This would cost approximately $21 million in additional revenue. National formulas should be fair and not harshly penalize the Midwest.

AN EMERGENCY MATERNITY AND INFANT CARE SERVICE SHOULD BE DEVELOPED AND PILOTED FOR THE UNINSURED WOMAN AND HER INFANT TO AGE EIGHTEEN MONTHS.

If we are to reduce infant deaths and promote the health of women in our country, we must provide on an interim basis, emergency comprehensive maternity care. This would be aimed at the recently unemployed and provide family planning, prenatal, labor, delivery and postpartum care, pediatric care for the infant to eighteen months of age and health education, nutrition and medical social work services to the family.

FINALLY, IT IS RECOMMENDED THAT A NATIONAL CHILDREN'S TRUST FUND BE ESTABLISHED TO DEVELOP INNOVATIVE APPROACHES FOR PROMOTING THE HEALTH AND WELFARE OF CHILDREN, YOUTH AND FAMILIES.

A National Children's Trust Fund should be established to promote small scale trials of new and innovative approaches to maternal and child health service delivery which might prove beneficial to the nation as a whole.

The National Children's Trust would place "venture capital" in the hands of those public and private agencies and institutions which are capable of designing sound approaches to the development of improved health protection services for our mothers and children. This important step would constitute an investment by Americans in their future.

Again, Mr. Chairman, thank you for the opportunity to speak to you today regarding the Maternal and Child Health Block Grant.

SAFEGUARDING THE HEALTH OF MOTHERS AND CHILDREN

By:

Gloria R. Smith, Ph.D., M.P.H., F.A.A.N.
Director
Michigan Department of Public Health

Joint Economic Committee
Washington, DC

Hearing
November 17, 1983

EXECUTIVE SUMMARY

As we have done in the past, we look to the national level for leadership in dealing with a very important issue--the health of mothers and children. This has become even more critical due to recent poor economic conditions and unemployment, and their impact on maternal and child health in Michigan and the United States.

In Michigan, a snapshot picture in January 1983 showed a state of economic depression, serious reductions in fiscal resources and unprecedented need and demand for human services. A key indicator was the infant mortality rate which showed a jump from 12.8 deaths per 1,000 live births in 1980 to 13.2 deaths per 1,000 live births in 1981, its greatest increase since World War II.

Progress has been made in Michigan since January 1983 through a tax increase coupled with budget cuts and employee reductions; and Governor Blanchard's ambitious economic development program. But problems remain. Michigan still has double digit unemployment and over 500,000 people out of work. While the infant mortality rate in 1982 resumed an encouraging downward trend to 12.1 deaths per 1,000 live births, Black death rates showed no improvement. In Detroit, the infant mortality rate remained unchanged and is twice the national average. Low birthweight ratios improved slightly for whites, but worsened for Blacks.

There are unmet needs for mothers and children in Michigan. Within the handicapped child population, funding increases are needed to service the families of the unemployed and keep pace with the high cost of specialty care. In maternal and child health programs, 1983 produced severe fiscal problems coupled with significant increases in categorical program demand and services provided, much of the increase resulting from the "new poor" population. Jobs Bill funding gave a badly needed infusion of dollars which allowed all 48 local health departments in Michigan to provide maternal and child health services, with an emphasis on maternity and infant care; which allowed us to raise the WIC caseload from 83,300 in April to 132,000 at the end of October.

Even with the one-time funding, there are still unmet maternal and child health needs. A particularly serious problem is the lack of early and continuous prenatal care. Shortly, if resources can be found, we plan to recommend pre and postnatal care be implemented on a phased basis beginning in 1984-85, with full implementation in 1985-86. This would allow all women in need of the service to receive it.

Maternal and child health programs are cost effective and emphasize prevention. These programs should be expanded, especially in periods of high unemployment and economic distress. It may be a question of pay now, or pay later. Prevention programs such as family planning, pregnancy care, infant care and environmental hazard control need to be provided on a population-wide basis.

Children are our most valuable natural resources. Maternal and child health programs not only improve health and enhance the lives of children immediately, but also expand the potential for significant contributions to the nation as a whole.

We offer the following five major recommendations in response to the needs of mothers and children. They include a proposal to double the Maternal and Child Health Block Grant by FY 84/85.

RECOMMENDATIONS

- FUNDING CUTS THAT HAVE CRIPPLED AMERICA'S MATERNAL AND CHILD HEALTH PROGRAM SHOULD BE IMMEDIATELY RESTORED AND THE MCH BLOCK GRANT SHOULD BE DOUBLED BY FY 1984/85.

- A NEW UNIT FOR CHILDREN, YOUTH AND FAMILIES SHOULD BE ESTABLISHED AT A HIGH LEVEL WITHIN THE UNITED STATES PUBLIC HEALTH SERVICE.

- FUNDING SHOULD BE RESTORED TO THE TITLE X FAMILY PLANNING PROGRAM.

- AN EMERGENCY MATERNITY AND INFANT CARE SERVICE SHOULD BE DEVELOPED AND PILOTED FOR THE UNINSURED WOMAN AND HER INFANT TO AGE EIGHTEEN MONTHS.

- FINALLY, IT IS RECOMMENDED THAT A NATIONAL CHILDREN'S TRUST FUND BE ESTABLISHED TO DEVELOP INNOVATIVE APPROACHES FOR PROMOTING THE HEALTH AND WELFARE OF CHILDREN, YOUTH AND FAMILIES.

SAFEGUARDING THE HEALTH OF MOTHERS AND CHILDREN

by

Gloria R. Smith, Ph.D., M.P.H., F.A.A.N., Director
Michigan Department of Public Health

Introduction

Health promotion and disease prevention programs for mothers and children have been organized principally in response to national leadership since the creation of the original U.S. Children's Bureau in 1912 and the passage of the Sheppard-Towner Act in 1921.

These programs and services have always had as their basis two important tenets:

- Improvement of the health of mothers and children is an important corridor to better health for the entire population. Mothers and children constitute a highly strategic group; they are especially vulnerable to hazards and attendant problems of reproduction, growth and development and at the same time are the segment of the population which is most responsive to health care.
- The health of mothers and children is closely related to the general health of the community and to the social, economic and cultural background of the country as a whole. Measures which improve the general public health will benefit mothers and children.[1]

It is my belief that national leadership is needed even today. Is America any less concerned for its children than it was over seventy years ago?

It is the purpose of this brief report to: reveal the tragic impact of high unemployment rates on the health of mothers and children in Michigan;

discuss current and future economic prospects for our state; review unmet needs; demonstrate that prevention strategies will contain health care costs; and set forth recommendations for consideration by the Joint Economic Committee.

The Impact of Unemployment on the Health of Mothers and Children in Michigan

In January 1983, the Michigan Department of Public Health conducted an intensive review of the impact of unemployment on the health of our mothers and children.[2] The results were startling; we found that a human emergency existed at that time and that Michigan was in the worst economic condition of any state in the Nation. We were in the 37th consecutive month of double digit unemployment, with more than 740,000 people out of work. This is a larger number of individuals than the entire population of many states in the union.

About 20,000 workers were exhausting their regular unemployment benefits every month and well over 100,000 had exhausted their extended benefit period. The number of persons receiving some form of public assistance had increased 35 percent over the previous 48 months and 15 percent of our total population were receiving some form of public assistance.

Michigan's economic and human crisis had come at a time when the state was least able to cushion the many tragedies which threaten family life.

Tax collections were down. The state treasury was $900 million in the red. Past bookkeeping practices had added another $800 million. After three years of state cuts, hiring freezes and program terminations, we were facing a new round of $225 million in reductions. Our Department had lost $24.2 million in the previous sixteen months and the Maternal and Child Health Program $6.7 million during the same period.

The following illustrate some specific examples of the impact of declining funding levels for maternal and child health programs in Michigan in the January 1983 period.

Maternity and Infant Care

In the seven projects outside of Wayne County, local staff reductions total 11.6 FTEs coupled with a 10 percent reduction in clinic capacity. Over $300,000 have been cut in personnel and clinic costs. In the large project in Detroit and Wayne County (MIC-PRESCAD), three major health centers have been closed, affecting 600 women and almost 11,000 children. Over 15 professional staff positions have been eliminated and several services contracts have been terminated or reduced.

Crippled Children Programs

Staffing levels in the program have declined over the last few years through attrition. The program has been unable to fill positions due to a hiring freeze and insufficient financial resources. As a result, it has become increasingly difficult for the program to monitor and evaluate service providers, conduct training, develop treatment standards and provide case management and quality assurance activities. Some diagnostic categories may be cut this year.

Improved Pregnancy Outcome Program

This program in Michigan was aimed at improving the pregnancy outcome of pregnant teenagers. It was cut 30 percent in its fifth year leading to termination of all four program sites on a phased basis. All federal funding for this program will be exhausted by June 30, 1983, and the program will terminate.

Family Planning

In the state funding period beginning January 1, 1982, local family planning projects were reduced by 25 percent. This is

due to a reduction in federal Title X and state funds. The 75 percent funding level will reduce family planning services by 21,500 patients and result in nearly 9,700 unintended pregnancies. The funding picture is greatly compounded by a change in federal allocation of Title X funds to regions. Region V (Michigan, Wisconsin, Minnesota, Indiana, Illinois, Ohio) has been affected most adversely, and Michigan in particular. Efforts were made to reverse or modify the federal formula decision. This failed and the Michigan cut of 37 percent will apparently stand unless supplemental funds are made available again this year. Other states received cuts as low as 4 percent.

Amputee Center

Only last minute intervention by the White House overrode plans by the Department of Health and Human Services to defund our regional Amputee Center in Grand Rapids.[3] The Center provides artificial limbs and training for children.

Those served by the Amputee Center were only the tip of the iceberg when it came to economically deprived or handicapped children. The original rejection stated that the Amputee Center was "not of regional or national value".

The reductions we had experienced in the maternal and child health block grant to that January 1983 date made it impossible for us to shoulder all of the competing needs for service. Our State fund reductions were every bit as bad, if not worse, than the federal cuts.

Thus, services were being reduced at a time when demand from the unemployed and the medically indigent were increasing exponentially.

Blue Cross and Blue Shield of Michigan reported a drop of 556,633 participants since 1979. Medicaid rolls had only increased by 106,000.

Social Service officials estimated only one-tenth of the 20,000 people per month who exhaust unemployment benefits qualified and were enrolled by the Medicaid Program.

Michigan Hospitals reported $142 million of unreimbursed care was given in 1982, up 29 percent from 1981. Some community hospitals are threatened with insolvency.

The economic downturn was the foundation of the picture seen in Michigan at that time of poverty, hunger, lack of access to health care and high infant mortality.

The infant mortality rate in Michigan had just been shown to have increased from 12.8 deaths per 1,000 live births in 1980 to 13.2 deaths in 1981. This increase represented a disturbing reversal of a 30-year trend which saw the infant mortality rate cut by 50 percent. Some areas of the state had realized a 100 percent increase in one year, and inner-city Detroit was one of the places where the problem became the worst.

A survey by the Statewide Nutrition Commission indicated that reliance on emergency food providers was increasing and that most programs experienced a doubling of their caseloads over the previous year.

Behind the statistics were the families living a nightmare of worry about their ability to provide for their children.

Family A - This was a two parent family with two children, living in the Lansing area. The husband was furloughed in September 1981. Unemployment compensation is hardly enough because their son is a diabetic. They were unable to meet all of their needs for rent and food while paying for expensive medicine and physician bills. The Crippled Children's Program was able to assist somewhat with medicine but it was difficult for them to get through. This family was only eligible for $43.00 a month in food stamps. The

father is hoping to be called back to work in February 1983. He was employed at a sod plant.

Family B - This was a two parent family with two children. The father was a laid-off trucker. They had no income and were still waiting to hear from the unemployment office to see if he would be eligible for benefits. There were no savings. His wife had recently suffered a heart attack. A hospital social worker was trying to arrange for deferred payments.

Family C - This was a rural family of six. The father worked 9 years for National File Company in Leslie. He was a lead welder. He was laid off and was being periodically called back for four days. Sometimes this caused him to lose any unemployment benefits. At other times, he received unemployment for two to three weeks. They have children on the WIC Program. The baby, age 6 months, with the help of WIC is growing normally. Another child, age 4½, has a low iron count. Diet in the home has been poor due to lack of regular income. Although this family raises all their own food, cans it, etc., diet analysis show insufficient nutrients.

Between 1978 and 1979, Children's Hospital of Michigan average census in the neonatal intensive care unit (NICU) was 37 infants.

Baby A - was a 1200 gram premie born to 19-year old parents on welfare. The parents were only able to visit once a month over the 14 months this infant spent in the hospital. They could not afford bus fare to visit their infant but they called the unit often. They borrowed money from relatives in order to spend time at the hospital learning to care for the baby at home when discharge was imminent.

Baby B - was a sick premie with lung disease. His mother and father lived in a car, and thus had no telephone or permanent address. The mother received no prenatal care and the family lived on handouts from neighbors and hospital staff. They wanted to visit the baby but could seldom afford gasoline for the car. They visited a few times. The baby died at 7 months of age. The mother was pregnant again at this time and delivered a stillborn in the car five days after her first baby died. The state paid for a double funeral. This was not the only family known to Children's Hospital living in a car.

Clearly the economic depression in Michigan, the state's fiscal situation and the unprecedented need and demand for human services were all extraordinary conditions. These were not unique to any particular area of the state. There were some families in critical need of basic food, clothing and shelter in nearly every community.

Current and Future Economic Prospects for Michigan

In January of 1983, Michigan elected a new Governor, James Blanchard. From the time he took office, Governor Blanchard has moved forcefully to get Michigan moving again.

The first major hurdle to overcome was the state's insolvency. Governor Blanchard, together with legislative leadership announced a combined program of budget cuts and state employee reductions with a state tax increase. The plan passed and it has worked. Today, Michigan is reaping the benefits of a balanced budget and has found new confidence on Wall Street as debts incurred by the previous administration are being paid at an accelerated rate.

A constant and steady stream of economic development initiatives has come from Governor Blanchard. They include:

- Summer youth jobs program which employed over 25,000 last summer.
- Pilot programs to provide employment, skill training, education and energy assistance to welfare recipients.
- A computerized technology network to let business tap the technological expertise of the five state universities.
- Export increase initiatives for Michigan products to enter more world markets.
- Promotion of the state's human, economic, and natural resources to the rest of the nation.
- Assistance for Michigan business to obtain a greater share of federal procurement contracts.

Many other plans are part of Governor Blanchard's 20 point economic development program. Michigan is on the move and to characterize the Michigan of November, 1983 as "empty smokestacks" and "bread lines of citizens" is incorrect.

The auto industry after retooling its plants and introducing many new plans and technologies is showing record-breaking profits. This is a remarkable feat in the face of the previous 3½ year U.S. sales slump. Ford announced a record $333.1 million third-quarter profit and G.M. made a record $736.7 million in the third-quarter. Chrysler also entered a profit of $100.2 million in the third-quarter while AMC posted a small loss of $9.1 million.

Of course many problems remain. Michigan still has a double digit unemployment rate of 13.6 percent with 573,000 people still jobless. With increased consumer spending forecast for this Christmas we are hopeful of bringing these high rates down.

Demographers are predicting that Michigan's era of rapid population growth has ended and only a limited increase is expected for the remainder of the century.[4] This occurrence, however, may offer Michigan with a fruitful opportunity to increase

the quality of life. It is almost likely that in contrast to our current labor surplus, Michigan may again become a large labor importer in the 1990's principally because of the aging of our workforce and population.

Also, final county of residence infant mortality figures for 1982 show that Michigan has resumed an encouraging downward trend in this important health status indicator. The 1982 infant mortality rate is 12.1 deaths per 1,000 live births. This compares to a rate of 13.2 for 1981, a year in which Michigan had one of the greatest increase in infant mortality since World War II.

The statewide improvement for 1982, however, does not extend to all sub-populations in Michigan. Detroit's infant mortality rate remained virtually unchanged (1981 = 21.9, 1982 = 21.8). Statewide, black infants continue to die at over twice the rates of white infants (white infant death rates in 1981 = 10.9, 1982 = 9.7; black infant death rates in 1981 - 24.8, 1982 = 24.6) and the gap actually worsened in 1982. It is also disturbing to note that while low birth weight ratios improved slightly for whites, they worsened for blacks. Also, more deliveries with no or low prenatal care occurred to blacks in 1982.

While overall the 1982 rate is down, Michigan has a higher level of infant mortality than expected had our improvements in the late 1970's continued. Calculations based on rates for 1976 through 1980 predicted that Michigan's infant mortality rates should have declined to 12.2 in 1981 and 11.7 in 1982. The actual rates of 13.2 and 12.1 for 1981 and 1982, respectively, compare unfavorable with the predicted rates. In effect, Michigan lost a few years of progress and an estimated 194 more infants than expected died during the two year period.

When the same analysis was performed for the United States as a whole, predicted infant mortality rates for 1981 and 1982 were 11.9 and 11.3. The observed provisional rates were 11.7 and 11.2. Thus, the United States actually performed better than expected in 1981 while Michigan was doing worse than expected. In 1982, the United States performed almost exactly as predicted.

Much work still remains for Michigan. But we feel that the state is feeling renewed optimism and is responding to the new directions set forth by Governor Blanchard.

Unmet needs for mothers and children

A. Crippled Children

The Crippled Children Program is included in the MCH Block Grant and is essential to handicapped children services in Michigan. The need and demand for this program's services has increased substantially because of the following factors:

- Increased clients

  High unemployment in Michigan continues to increase the number of residents receiving support for medical care and treatment. During the recent years of recession, the number served rose from 12,800 in FY 1980 to 14,000 in FY 1983. We also know there are many children with unmet needs not being reached.

- Increased costs

  The medical care and treatment services supported by this program are mainly specialty care services for certain severe conditions. The expenditures have increased from $16.26 million in FY 1980 to $23.02 million in FY 1983. While there have been some changes in specialty care, inflation has been the major cause of this rise which includes a $3.8 million increase just in the last year.

The MCH Block Grant also includes funds for the Supplemental Security Income/ Disabled Children's Program. Its purpose is to provide case management service to individual multidisabled children approved by the Social Security Administration. We know from experience gained from delivering these services that they greatly improve the effectiveness and efficiency of response by existing resources to

these children and their families. Yet, the program is only serving children from birth to 7 years of age while those up to 16 years of age are eligible, and we are trying to expand the services from thirty-five counties now served to all eighty-three counties in the state.

The improvement of these locally-based services for the children in both the Crippled Children Program and the Disabled Children's Program has a very high priority in Michigan because it does increase the efficient use of existing resources and the effectiveness of that response which will stretch our available dollars to more children. We estimate that 3 million dollars above our current appropriation is needed to support this project. The following actions are being taken by our Department:

- A major portion of CCP expenditures are for inpatient hospital costs related to newborns (about 7 million of 12.5 million dollars total). We are, this month, beginning to build standards of care to move some ventilator-dependent children from intensive care settings to home-based, complex care where appropriate. The savings can be 20-50,000 dollars per child, and it is hoped that ten to fifteen children might be relocated for care beginning next August when the standards are completed.
- We are confident the improvement of locally-based services for clients of these two programs across the state will prove to be economically sound despite the upfront costs of several million dollars. Responding more effectively to the needs of these children and their families should stregthen the family unit as a productive structure in addition to helping each child achieve his greatest potential for self-support and independence.

Services to crippled children are directly affected by economic factors. Both have increased, especially the costs of medical care and treatment.

Michigan is trying in many ways to respond to the need by stretching available dollars. However, increased resources are urgently needed to support the improvement of local services noted above and an expected rise in medical care and treatment. This money is a solid investment which can generate savings from related government support many times over by assisting the handicapped children and their families to be productive members of our society.

B. Maternal and Child Health

During the past several years, the State of Michigan has been faced with severe fiscal problems which resulted in reductions in services at both state and local levels. Local public health departments have suffered from cutbacks. The problem is compounded by a growing need for services that are delivered by local health departments. Even where federal and state funding to local health departments has been maintained, increased demand for service cannot be met.

Four Maternal and Child Health programs operated by local health departments were selected for study in the spring of 1983 prior to passage of the Jobs Bill. These programs were Family Planning; the Supplemental Food Program for Pregnant and Lactating Women, Infants and Children (WIC); Maternity, Infant and Child Health Clinics (MIC) providing prenatal care, and infant and child health services; and the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) providing services for Medicaid eligible children. Family Planning, WIC and EPSDT programs are available on a statewide basis while MIC programs are operated in selected jurisdications.

The study focused on an identification of need, numbers served, and cost for each of the four programs. In addition, fourteen local health departments were

contacted and asked for an assessment of changing demand for services. The following reflects the information collected at that time:

Program	Estimated 1982-83 Need	1981-82 # Served	% Served	Total Dollars
Fam. Plan.	548,909	82,546	15	$5.682M
WIC	257,671	95,391	37	34.118
Prenatal-MIC	29,250	6,400	22	- - -
Other Infant/ Child	227,750	25,313	11	7.477
EPSDT	712,500	118,837	17	9.789

There were significant increases in categorical program demand and services provided throughout Michigan and most of this increase seems to have come from the "new poor"--i.e., persons who have assets, but no cash due to recent unemployment.

In Family Planning seven of the fourteen surveyed local health departments expanded clinic hours and services while six are showing increased waiting times. Thus, 12 of the 14 surveyed departments showed significant increases in demand.

In WIC, service hours have been expanded in four local health departments, five others have increased waiting times while two others are serving substantially more people than one year ago. Ten of 14 show increases in demand.

Ten local health departments are seeing more EPSDT clients than a year ago though all agree that the reason for this is that they are doing their own outreach and no longer depend on the Department of Social Services for referrals.

Ten of the 14 departments mentioned they are seeing significant numbers of "new poor" clients.

There were also significant increases in demand for family planning throughout the system. Several local health departments have responded by increasing their clinic hours or maintaining them with fewer dollars (Branch-Hillsdale-St. Joseph; Genesee; Central Michigan; District Health Department #3; Detroit; Marquette and Muskegon).

Increased waiting times are also being experienced by several:

Branch - from one month to two to three months
Tuscola/Lapeer - "significant" increases
Ingham - 464 not seen in January/February of 1983
Oakland - waiting lists for the first time
Central Michigan - from two weeks to four weeks
Saginaw - from zero to two weeks to three to four weeks
Berrien - from zero weeks to two to three weeks
Detroit - from one to eight weeks

In addition, District Health Department #3 began seeing 800 cases as compared to 500 a year ago; Marquette saw 350 cases in 1982 as compared to 190 in 1981; Oakland has reduced clinic hours due to declining money and District Health Department #1 estimated it is serving only 9 percent of those eligible. Muskegon has reduced waiting times from six to three weeks because of expanding hours and available services. In Detroit, increases were significant especially among patients without private insurance. The increased demand is reflected in more appointments being made, fewer being broken, and increase in requests for community education sessions.

Clinic hours were also expanded in WIC to meet increased demand in Genesee, Muskegon, Central Michigan and District Health Department #1.

Significant increases in waiting times were being experienced by:

Branch, Hillsdale, St. Joseph - unspecified but 550 waiting in January
Tuscola/Lapeer - unspecified
District Health Department #3 - 200 on list versus none a year ago
Berrien - unspecified
Detroit - 2500 high risk children

In addition, Oakland has a constant 6-12 month delay for children. Ingham, District Health Department #1, District Health Department #3, and Marquette are

seeing substantially more clients, and Saginaw is seeing increasingly severe cases. Detroit has increased caseload by 1000.

The most significant finding for EPSDT was that several local health departments were increasing their service levels to meet their quotas through the use of their own outreach workers. These included Branch-Hillsdale-St. Joseph; Genesee; Oakland; Central Michigan; District Health Department #3; Berrien; Muskegon and Marquette. In addition, Muskegon is experiencing waiting time in this program (two weeks).

In Detroit, the caseload went up 6000 from a year ago and waiting periods varied from 1-6 weeks. Reductions in outreach workers due to budget cutbacks led to increased transportation needs and increases from 25 to 40 percent in unopened cases.

Ingham County had maternal waiting lists for the first time and the children's waiting list has gone from two to four weeks.

In Detroit, waiting lists went up 10% over a year ago with substantial increases in telephone requests for service or service referrals from people who no longer have insurance.

Central Michigan - no change
Saginaw - more complex cases
Berrien - added clinic hours

There seems little doubt that the sharp increases in Family Planning, WIC and MIC clients represented a new type of category of clientele which are loosely described as the "new poor". Ten of the fourteen responding local health departments (Branch-Hillsdale-St. Joseph; Ingham; Oakland; Central Michigan; District Health Department #1; District Health Department #3; Detroit; Saginaw; Muskegon and Berrien) indicated they were seeing sharp rises in newly poor or cash poor or recently unemployed persons. These were persons who had never before sought medical assistance or who had not sought it in several years.

In Detroit, the following patient insurance data was collected in the family planning program:

Patient Insurance	1979-80	1980-81	1981-82
Medicaid/GA/None	87,769	100,165	113,238
BC/BS - Other Private	35,982	33,150	28,434

Other findings from the MCH survey were:

- Monroe and Saginaw Counties reported that increased staff energies are needed to deal with increasingly complex cases.
- Genesee County reported new large increases in the demand for primary care.
- Oakland reported large increases in demand for venereal disease, immunization, and dental services (dental has a four month wait).
- Branch-Hillsdale-St. Joseph indicated that local doctors are being swamped and that few are taking new cases or Medicaid babies.
- District Health Department #3 indicated that school-aged children are not getting preventive care.
- Berrien indicated that the school systems are sending sick children to the local health department for treatment.

The "Jobs Bill" which passed the Congress last Spring gave the Michigan Public Health System a badly needed infusion of roughly $11 million, nearly evenly divided between maternal and child health, WIC supplemental foods and community health centers. These funds were immediately programmed, and were out working in all local health departments in the state by mid-Summer. Let us share with you some of the impressive results.

Maternal-Child Health

An allocation formula based on need, using such variables as high

unemployment and low birthweight rates was developed and for the first time MCH funds were given to all local health departments to establish service programs. These new activities include provision of prenatal care, health education and infant care to reduce high infant mortality. Badly needed school health and community nursing services were restored. Family planning services were expanded in several local health departments and accident prevention programs, like child auto restraint seats loan services were established.

WIC

The Michigan WIC Program had one of the largest expansions of any program in the nation. At risk and poor women, infants and children were enrolled through a coordinated and intensive state/local outreach effort which saw the WIC caseload jump from 83,300 in April to 132,000 at the end of October. This vast increase of 58% attests to the serious health problems Michigan still faces. Even with the new caseload we are only able to serve about half of the women, infants and children believed to be eligible for nutrition supplements.

Even with this "one-time" money, Michigan continues to have many unmet maternal and child health needs. These problems or needs can be grouped into categories set forth below.

Infants Under One Year

Low birth weight, birth defects, infectious diseases, birth injuries, sudden infant death syndrome, and inadequate parenting.

Children, 1-14 Years

Hearing and speech problems, vision problems, child abuse and

neglect, developmental disabilities, accidents, infectious diseases, chronic handicapping conditions, pediatric antecedents of later chronic diseases, and other problems of growth and development.

Adolescents and Young Adults, 15-24 Years

Accidents, suicides, homicide, substance abuse, teenage pregnancy, and difficulty in learning health lifestyles.

Adult Women of Reproductive Age

Pregnancy planning, impact of personal and environmental health risks on pregnancy, infectious disease, access to primary care services, and maintenance of healthy lifestyle.

These problems are described in detail in Health Promotion and Disease Control: Report of the Harrison Committee, MDPH, 1982.[5]

Let me give you an example of a particularly serious problem for Michigan, lack of early and continuous prenatal care.

The President's Commission issued a recent report entitled, Securing Access to Health Care.[6] The report estimated that 8% to 11% of the U.S. population was without any form of health insurance. While this percentage rises and falls with economic cycles, our country has long had the problem of about 10% of the population falling through the cracks.

This problem is particularly serious for mothers and children. Some of the most serious and expensive hospitalizations can be avoided if access to preventive health care is assured. Early and comprehensive prenatal care is one of these critically needed preventive health services. Current medical standards strongly recommend that care begin in the first trimester and be continued until delivery, with an average of 12-14 visits providing optimal outcome if the pregnancy is normal. High risk patients may require significantly more care.

There are large groups of women in Michigan who do not receive adequate prenatal care at this time. For example, in 1981, there were 8,160 women who had five or less prenatal visits and of this group 930 were reported to have no prenatal care. Infant death rates in this group range in the 60-80 infant deaths per 1,000 live births, dramatically higher than those with the recommended standard of 12-14 visits. Low birth weight rates follow the similar trend, with those in the five or less prenatal visit group having three times the number of low birth weight infants as those in the average childbearing population.

In 1981, there were 140,579 live births. Approximately 14,058 can be assumed to have delivered with no Medicaid or other third party insurance. It is also interesting to note that 8,160 women delivered in 1981 with five or less prenatal visits when the recommended standard is 10 to 12 visits.

Prenatal and postpartum care can be given at an average cost of $300. This cost includes 10-12 visits with the physician, routine laboratory and radiology tests, expectant parent education, nutrition and psycho-social screening.

Shortly, if resources can be found, our Department will recommend that pre and postnatal care be implemented on a phased basis beginning in FY 1984-85. Full implementation would be scheduled for FY 1985-86. The costs are reasonable.

	Local Service	Local Administration	State Administration	Total Funding Request	Patients Served
1984-85	2,127,500	$212,500	$160,000	$2,500,000	7,100
1985-86	4,200,000	420,000	315,000	4,935,000	14,000

Our Department's Management Plan for FY 1984/85 if approved at a 10% across the board reduction in state general funds would include a substantial reduction in the current level of family planning services; 24,800 fewer patients would be served and we estimate this would result in 10,910 unwanted pregnancies. Even if we stay at a continuation level, we could not even begin to meet the documented

needs of our mothers and children. To summarize:

EPSDT - 130,020 screens or 39% of the target

Family Planning - 61,000 clients or 14.2% of the need

Genetics - 7,000 sickle cell screens or 13.3% of the need

Hearing and Speech - 60% of all local service requests met

Lead Paint - 17,000 screens or 26% of the target

Local MCH Services - 42,250 mothers and children served or 6.7% of the estimated need

Rape Counseling - 38% of local project requests funded

Perinatal Care - 75% of hospitals have all level III components of care

MCH Demonstrations - 13% of local requests funded

Sudden Infant Deaths - 175 autopsies and 330 counseling visits performed for 50% of the need

Vision - 66% of all children under eye screening programs, and 50% of all needed consultant services provided

WIC - 132,000 clients served for 50% of the need

Most of the above service levels do not come very close to meeting actual service needs. This is historically the case for many public health programs, but especially for those involving mothers and children. If $1 were spent for public health prevention early in life for every $10 that is spent on acute illness and hospital care, it is well known that significant health benefits could occur to Michigan society.

We have other important new areas of need that should be addressed. Two examples among many are presented below.

Prenatal Management of Sickle Cell Anemia

Sickle cell anemia is one of the most common genetic diseases, occurring in 1 in 600 Black newborns. In the State of Michigan, 220 couples at risk have approximately 45 affected newborns per year. It is not unusual for affected persons to incur medical

expenses of $10,000 per year and few affected adults are employed. The presence of one or more affected children places a great strain on the resources of a family and greatly influences its lifestyle. Until recently, foregoing parenthood was the only sure method for couples at risk to avoid having a child with Sickle Cell Anemia. It is now possible to assure that couples at risk who wish to have their own biologic children can do so without the threat of having one with Sickle Cell Anemia. Recent developments in recombinant DNA research have made prenatal diagnosis (PND) inexpensive, safe, and accurate.

If funded, the target population is 220 Black couples at risk for offspring with Sickle Cell Anemia.

The project will promote use of this new technique for prenatal diagnosis of Sickle Cell Anemia to all families at risk in the State of Michigan. The process will include genetic counseling by trained counselors to assure that 50 couples known to be at risk will receive accurate counseling free of coercion. Follow-up counseling will also be performed.

Teratogen Hotline and Registry

A non-controversial and effective means of preventing congenital malformations is the avoidarce of teratogenic agents during pregnancy. A teratogen is an agent or factor, such as radiation or drugs, which causes the production of physical defects in the developing embryo. It is unreasonable to expect family practice physicians, internists, and obstetricians to maintain current files and information on the teratogenic potential of the increasingly vast array of environmental agents to which pregnant or potentially pregnant women are exposed. At the same time,

however, there is increasing awareness among physicians, and increasing concern among women, of the potential effects of environmental agents on the unborn child. In Michigan, there is currently no single, well-known, easily accessible and up-to-date source of information to address these concerns.

The NIH Collaborative Perinatal Study (1977) surveyed 60,000 pregnancies. Eighty percent reported prenatal drug exposure to over 900 different drugs. The average pregnancy was exposed to 4 different drugs exclusive of nutritional supplements. Forty percent of exposures were during the first trimester. In Michigan, the population at risk is approximately 110,000 pregnancies each year which are exposed to potentially teratogenic drugs.

The Michigan Teratogen Hotline will provide pregnant women, physicians and other health care professionals with up-to-date and accurate information regarding the teratogenic effect of the multitude of agents to which a pregnant woman may be exposed. These agents include, but are not limited to, prescription drugs, over-the-counter medications, diagnostic and therapeutic radiation, and chemical exposures from the environment, either by vocation or avocation, of the pregnant woman or the woman who is planning a pregnancy. Also, the project will gather data for correlations of exposures and abnormalities in morphogenesis.

If funded, 2,500 consultations will be delivered by the hotline in FY 1984/85.

Prevention Strategies will Contain Health Care Costs

The greatest growth in health care costs have come from the entitlement programs, such as Medicaid. Cost effective programs which emphasize prevention and earmark funds to the most needy should not be cut since these programs have been able to provide services to increased numbers of persons and streamline costs during a period of high inflation. This is particularly true in periods of high unemployment and economic distress since the health of mothers and children is often the first to suffer (e.g., Michigan increase in infant mortality between 1980-1981).

Maternal and Child Health Programs are cost-effective:

- A federal GAO report published on February 27, 1979 indicated that for each $1 spent on WIC there is a savings of $3 which would have been spent caring for a low birthweight infant and for each $150 million spent on WIC $260 million is saved in federal expenditures for Medicaid, Supplemental Security Income and special education.
- The Center for Disease Control in Atlanta showed that children enrolled in WIC had considerable improvement in blood hematocrit values (reduction in anemia). An Arizona study recorded an 81 percent reduction in anemia, 82 percent reduction in underweight infants, and 64 percent improvement in children's height.
- A national study conducted by the Alan Guttmacher Institute demonstrated a benefit/cost ratio of $1.80 for every federal dollar invested in family planning.
- Medicaid children participating in the EPSDT program have achieved immunization levels of 82 percent in comparison to the state average of 68.6 percent for all Michigan children.

Every dollar spent on immunization saves an estimated $8.00 in treatment costs.

- Medicaid children participating in rescreening after two years in the EPSDT Program had an 8 percent reduction in problems needing referrals.

- One percent of the children participating in EPSDT screening were referred for diagnosis and treatment of excessive blood lead levels. Left untreated, lead poisoning can result in a wide spectrum of morbidity including behavioral problems, mental retardation and in death.

- Maternity and infant care projects (MIC) in Michigan have contributed to a decline in maternal and infant mortality. A study completed in 1979 showed that women who had delivered their last pregnancy outside the Michigan MIC projects suffered a perinatal mortality rate of 113 per 1,000 live births. Delivery within the project reduced this rate 26 per 1,000.[7]

- Federal government studies show that for every $1 spent on prenatal care, $4 to $6 are saved in neonatal intensive care (NICU) and re-hospitalization for low birthweight infants during the first year of life.[8]

It is Michigan's contention, however, that the dramatic reductions in infant mortality seen in the 1970's can only be matched in the 1980's if prevention programs such as the following are provided on a population-wide basis.

Family Planning
Education - professional and public
Nutrition
Medical Services
Genetic Counseling
Risk status assessment

Pregnancy Care

- Education and social support
- Nutrition
- Medical services, including delivery and pregnancy termination
- Genetic diagnosis and counseling
- Assessment of risk status

Infant Care

- Parenting education and social support
- Nutrition
- Medical Services
- Immunizations
- Health maintenance
- Early identification, diagnosis and intervention
- Surveillance and control of infectious diseases
- Neonatal intensive care

Environmental Hazard Control

- Education, professional and public
- Surveillance and control

These findings agree with those presented by Dr. Barbara Starfield of Johns Hopkins University.[9]

Dr. Starfield believes that elsewhere in the future, a greater portion of infant deaths will be linked to factors that can't be alleviated by technology, such as failure to receive prenatal care. Equity of access to neonatal intensive care units will undoubtedly worsen with Medicaid cutbacks, but the effects of this inequity pale in comparison to the results of reduced access to nontechnologic care due to decreased funds for prenatal care.

In one sense society can "pay now or pay later" in the form of higher rates of disease, tertiary medical care, death and/or institutional maintenance of the severely damaged child.

As today's children grow into adulthood, they will have to perform increasingly complex tasks in an age of technological change to protect our natural environment, maintain our standard of living and keep our economy competitive

with those of other nations. We must consider each of our children as a valuable national resource. Programs such as maternal and child health not only improve the health and enhance the lives of our children immediately, but also expand their potential for significant contribution to the nation as a whole.

The programs of the 1980's should be preventive in nature and based on a solid research base.

To summarize, there are many existing intervention strategies which are known to be highly effective. The routine application of these measures would result in improved health for Michigan's mothers and children. These strategies are:

Restoration of economic activity with strong efforts to include all U.S. sub-populations in the upswing.

Provision of food supplements as prescribed by competent health authorities for all pregnant women and infants who have inadequate diets.

Provision of early and continuous prenatal care, labor and delivery in a hospital setting and a six week post partum check up for all American mothers.

Provision of routine and specialized health care for the infant through the first 18 months to maximize each child's opportunity to reach his or her full genetic potential.

Provision of comprehensive voluntary family planning services which are consistent with the personal beliefs and values of each American.

Reduction in the use of alcohol and drugs in pregnancy by educating the American people on their dangerous effects and providing substance abuse centers for counseling and detoxification.

Why Add Resources to the Public Health System?

There are at least four reasons why development of alternative MCH service arrangements can best be accomplished by the state/local public health system. They are:

- statewide perspective
- population responsibility
- access to major financial and professional resources
- prevention focus

Public health problems which may be rare in any particular community, like the woman who delivers with little or no prenatal care or an infant born with a serious congenital defect, may, upon statewide inspection of all such events be shown to be a serious enough problem to justify a preventive or therapeutic program. Often information from periods of several years, across all communities is needed to form an accurate scientific picture.

The state/local system cannot evade or escape its responsibility to promote and protect the health of all Michigan mothers and children. This is quickly brought to mind when there are public concerns about the effects of toxic chemicals on reproduction or an upsurge in infant mortality.

While state/local health departments have diminishing financial resources, they often still have a good professional staff at their disposal. They also have credibility in the eyes of lay and professional groups alike. This can mean important coordination of scarce resources and bringing them to bear on important public health problems.

Finally, Public Health brings a strong commitment to prevention to the health care scene. Good health is more than an absence of disease. The maintenance of good health requires a far different set of strategies than the treatment of disease, important though that work be.

The Maternal and Child Health program selects from several alternative strategies in carrying out its responsibilities. They are:

- Investigate and report
- Targeted directly funded categorical programs
- A regionalized approach
- Research and development
- Planning, promotion and coordination
- Law, rule or regulation
- Information, education, training and quality assurance

When a serious health problem is detected, the first step is often an investigation and report (e.g., Infant Mortality in Michigan, 1981[10]). These reports present analyses and recommendations for public policy. Recommendations, once adopted, may involve implementation of one or more of the alternative approaches listed above. In the case of infant mortality a coordinated planning and promotion task force was created at the state level to guide development of a newly funded targeted categorical program aimed at reducing low birthweight and resultant infant mortality.

The perinatal intensive care and genetics programs are examples of a regionalized approach to service delivery. This approach attempts to provide lower cost primary prevention services in all communities and coordinate high cost services in only a few centers where there is demonstrated professional expertise, facilities and equipment.

The Michigan MCH Program has also conducted research and development of alternative ways to deliver services. One recently published article demonstrated the value of an existing categorical program ("The Report of Maternity and Infant Care Programs on Perinatal Mortality", Perinatology/Neonatology, Vol. 7, No. 8 August, 1983).

The work done on an integrated local approach which combines WIC, EPSDT, Family Planning and MIC Projects into a "Family Health Project", however, has demonstrated the feasibility of an alternative to the categorical approach. (The Family Health Project: An Experimental Block Grant Funding, MDPH, March 1983).

Many elements of this model will be implemented as a part of comprehensive planning and budgeting system to be in place by January 1985.

Finally, the Michigan Hearing and Speech and Vision Programs are excellent examples of an education, training and quality assurance approach combined with development of coordinated local health care systems. Small investments of the state level in planning and promotion have resulted in good local compliance with state screening laws for children.

Recommendations

It is our contention that some shift in spending priorities must occur. The erosion of our industrial base together with the massive increase in joblessness has weakened our State and the Nation. At this time, as always, mothers and children are profoundly dependent on us for their well-being.

FUNDING CUTS THAT HAVE CRIPPLED AMERICA'S MATERNAL AND CHILD HEALTH SHOULD BE IMMEDIATELY RESTORED AND THE MCH BLOCK GRANT SHOULD BE DOUBLED BY FY 1984/85.

The maternal and child health block grant was formed by consolidating many related programs and cutting them approximately 25 percent. The cost of returning this program to previous funding levels, with inflation, would require new appropriations of approximately $110 million. This would place the Block grant at a level of $483 million from the $373 million in the cutback base.

It is further recommended that the MCH block be doubled in size to the $750 million to $800 million level in FY 1984/85. Such an investment in America's future will contain spiraling hospitalization costs for mothers and children and help ensure that our children will reach their maximum social and genetic potential.

The State and local health department system is in place. Services could be increased immediately as they were with the one-time federal Jobs money. These services should be focused on pregnancy and infant care in order to have a maximum impact on infant mortality and morbidity.

States should be asked to put togehter a plan and budget which takes full advantage of all available resources that can address the priority health problems among their mothers and children.

In the development of the State Plan, it should take into account existing maternal and child health services which may be helpful in dealing with their identified problems, for example:

comprehensive maternity and infant care services

nutrition education and WIC Program, focusing on prenatal clients

family planning

perinatal intensive care system (including promotion of regionalized perinatal care, perinatal nurse educators, and developmental assessment centers)

genetic service available and accessibility

Sudden Infant Death Syndrome grief counseling and apnea monitoring

environmental health (reducing prenatal exposure to environmental agents; ionizing radiation, toxic substances, and other occupational hazards and stresses), including infant seat restraints

general consumer health education

It is strongly recommended that a national Maternal and Child Health Advisory Group be formed to direct the upgrading of maternal and child services to pre-cut levels.

A NEW UNIT FOR CHILDREN, YOUTH AND FAMILIES SHOULD BE ESTABLISHED AT A HIGH LEVEL WITHIN THE UNITED STATES PUBLIC HEALTH SERVICE.

With the dissolution of the beloved and productive Children's Bureau in the late 1960's, the United States found itself among a minority of developed nations without a strong national voice for children. The results have been tragic for the Nation's children.

The major charge of this new unit of government should be:

"To investigate and report on the conditions affecting the health and welfare of America's children, youth and families."

It is essential that timely and accurate information be maintained on the health status of children, youth and families. This must also include accurate

estimates of services rendered and the numbers of citizens in need of care who are not receiving such care. Such information is crucial for the President and the Congress as they discharge their duty to protect American family life.

Existing programs now operated by various branches of government should be realigned and many of them folded into the new administrative unit. Title X Family Planning and the Maternal and Child Health Block grant are two programs which should be transferred immediately.

There must also be strong program authority for coordination with other children programs like EPSDT, WIC supplemental foods and Head Start.

This unit should be responsible for carrying out the essential elements of a comprehensive maternal and child health program, including:

Studies aimed at identification and solution of problems affecting the health and well-being of mothers and children;

Organization of maternity services, including adequate prenatal, perinatal and postnatal care;

Continuing health supervision services for all children from birth through childhood and adolescence;

Organized programs of health education for parents, children of school age and the general public;

Establishment of standards for health personnel serving mothers and children and for facilities providing for their health care;

Systematic manpower development and training activities;

Continuing assessment of the efficiency and effectiveness of health services for mothers and children;

Conduct and support of operational research as a basis for further program planning and development

FUNDING SHOULD BE RESTORED TO THE TITLE X FAMILY PLANNING PROGRAM.

In the United States almost all people, regardless of ethnic, religious or socio-economic background, wish to voluntarily choose the number and spacing of their children. Comprehensive family planning services represent an effective means of dealing with the health, social and economic problems associated at least in part with the occurrence of unwanted and mistimed pregnancies.

The family planning Title X program should be restored to its previous level of $162 million from the current reduced level of $141 million. This would cost approximately $21 million in additional revenue. In addition, new funding formulas must be developed which do not penalize the Midwest.

Family planning clinics are in place throughout the country. They could quickly move to add approximately 480,000 medically indigent women to their clinic rolls. This would avert approximately 255,200 unplanned pregnancies and all the concomitant grief and suffering which accompanies unwanted pregnancies.

Several prevention/promotion measures have been identified in the area of family planning. They are made up of a variety of education, information and service delivery activities. Services available to each family planning client should include:

- Physical education
- Contraceptive supplies
- Venereal Disease counseling
- Education and Information
- Contraceptive counseling
- Treatment or referral for social problems
- Pregnancy testing
- Sickle Cell testing
- Infertility studies
- Sterilization
- Nutrition counseling
- Laboratory testing

AN EMERGENCY MATERNITY AND INFANT CARE SERVICE SHOULD BE DEVELOPED AND PILOTED FOR THE UNINSURED WOMAN AND HER INFANT TO AGE EIGHTEEN MONTHS.

As the Nation entered World War II, it was determined that an emergency maternity and infant care program was needed. Doctor William Schmidt describes how this program improved the Health of the Nation's mothers and children.

> The Second World War brought about a rapid, large-scale increase in the numbers of enlisted men. Many of their wives came to live

near posts where their husbands were temporarily stationed. The capacity of station hospitals to provide maternity care was soon found to be insufficient.

An emergency program developed with great rapidity, extending to servicemen's wives wherever they lived and providing care for one and a quarter million mothers and 230,000 infants by the time it was terminated after the end of the war. This was the largest public medical care program the country had known and the state health departments had ever dealt with.

It was entirely supported by general tax funds. There was no state matching, and there was no means test required or permitted for designated beneficiaries. It enabled states to make great progress in licensing and upgrading hospital maternity care and further aided hospitals to improve standards by establishing a basis of payment related to the cost of care--a principle later adopted by other federal agencies and by the Blue Cross insurance plans.

The rapidity of expansion of this program, its widespread acceptance and the general participation of physicians and hospitals overshadowed the scattered opposition initially encountered and a short-lived attempt of one state medical association to encourage a boycott of the program.

Accordingly, if we are to reduce infant deaths and promote the health of women in our country, we must provide on an interim basis, emergency comprehensive maternity care. This would be aimed at the recently unemployed and provide family planning, prenatal, labor, delivery and postpartum care, pediatric care for the infant to eighteen months of age and health education, nutrition and medical social work services to the family.

The cost of these services based on the Michigan experience is approximately $2850 per mother and infant pair, including labor and delivery costs. We now have an estimated 8,000 mothers and infants in Michigan who might quality for this emergency service.

If one pilot county were chosen to demonstrate the service, a research and development project could be conducted for 750 women/infant pairs for $2.1 million. Additional pilot counties could be added to gain experience in other parts of the country.

FINALLY, IT IS RECOMMENDED THAT A NATIONAL CHILDREN'S TRUST FUND BE ESTABLISHED TO DEVELOP INNOVATIVE APPROACHES FOR PROMOTING THE HEALTH AND WELFARE OF CHILDREN YOUTH AND FAMILIES.

A National Children's Trust Fund should be established to promote small scale trials of new and innovative approaches to maternal and child health service delivery which might prove beneficial to the nation as a whole. Basic biomedical and related activity already covered in research programs operated by the National Institute of Health would not be eligible for funding by the Children's Trust.

The Trust should be directed by a Commission appointed by the Congress.

The National Children's Trust Fund should be funded using a voluntary postage stamp surcharge program. This method of obtaining charitable donations at the national level has been successfully demonstrated by Switzerland, West Germany and the Netherlands. Under this system, each stamp in a particular commemorative issue carries a small surcharge of which 90 percent goes into the Children's Trust Fund and 10 percent is held for administrative expenses.

The speical Children's issues are widely purchased by collectors and citizens wishing to make a charitable donation. These issues are called "semi-postals". Children, flowers or animals are often featured on the stamps. Purchase is strictly voluntary. The Trust Fund would also open for the receipt of

tax-exempt gifts and donations from American industry, labor groups, foundations and individuals.

These funds would constitute an investment by Americans in their future.

The National Children's Trust would place "venture capital" in the hands of those public and private agencies and institutions which are capable of designing sound approaches to the development of improved health protection services for our mothers and children.

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Senator BENTSEN. Thank you very much, Ms. Smith.
Ms. Gittler, please proceed.

STATEMENT OF JOSEPHINE GITTLER, CODIRECTOR, NATIONAL MATERNAL AND CHILD HEALTH RESOURCE CENTER, AND PROFESSOR OF LAW, UNIVERSITY OF IOWA, IOWA CITY

Ms. GITTLER. Thank you, sir. I appreciate the opportunity to appear here today before you. I would like to try and give you an overview of what has happened with respect to funding relating to maternal and child health block grant programs. I know you are very familiar with the history of the authorization and appropriation for the title V maternal and child health block grant. I would just like to emphasize one thing in that regard--that even before the establishment of the block grant in 1981, the core programs that make up the block grant, the title V maternal and child health program, and the title V crippled children's program, had received some increases in appropriations in the preceding 10 years, but those increases have not even kept pace with inflation.

Thus in 1981, the purchasing power of a title V dollar was actually 27 percent less than it had been a decade earlier.

And then beginning in 1981, there were really significant reductions in the authorization level and appropriation level of MCH block grant programs. I would like to draw to your attention that the Congressional Research Service has determined that the constant service level for fiscal year 1984 for the MCH block grant would be $607 million, which is considerably below the current authorization level of $373 million and the current appropriation of $399 million.

In looking at the funding for the MCH block grant programs from a State perspective, there are several factors that I think are worthy of mention that have to do with the cumulative effect on State maternal and child health block grant programs, not only of reductions in appropriations for the MCH block grant, but also the loss of other Federal funds to these programs.

For example, let me just tell you what happened in Alabama.

Alabama actually has $1.4 million less in Federal funds for title V MCH block grant programs than it did in 1981. Now why is that? It has more title V MCH block grant formula funds than it did in 1981, but it has lost a number of title V discretionary grant funds. And I would like to emphasize that in many States, the maternal and child health block grant funds depend not just on formula funds, but they depend on discretionary grant funds under 15 percent of the appropriation that is set aside for funding of projects of regional and national significance. Alabama had a fair number of these which it has now lost. Alabama also lost community health center dollars, Federal community health center dollars. Alabama also lost Appalachian Regional Commission Federal dollars. Alabama also lost National Health Service Corps assignees. And so the cumulative effect of all of this is that Alabama is facing a deficit this year in its MCH program of $1.4 million. It should be noted in this regard that they have no State appropriations for their maternal and child health block grant programs; that is, they are very heavily, therefore, dependent on MCH Federal funds.

I would also like to note that there has been an interaction between the reduction in title V MCH block grant funds at the Federal level and reduction of Federal funding of medicaid which has posed enormous problems for the State maternal and child health programs and the State crippled children's program.

These reductions have translated in States into more stringent income eligibility requirements and more stringent limitations on coverage. And in many States, therefore, there are actually less women and children being served under medicaid than previously. These women and children have tended to turn because they do not have any other recourse to the title V MCH block grant programs in the States at the very time those programs are struggling with absorbing the cuts in Federal funding that have been given to them.

Let me briefly mention also that the situation with State funding is important in looking at the ability financially of the title V MCH block grant programs to cope with their mandate to improve the health status of mothers and children.

Now, it is very hard to generalize about this, sir, because there is such a wide variety in the levels of State fundings of these programs. They range from States like Alabama, which, as I mentioned a while ago has no State appropriation to States like California and Florida which have enormous State appropriations and where the title V MCH block grant Federal funds make up only a small portion of their total budget. And, of course, there are States everywhere in between Alabama and Florida and California on that spectrum.

The prevailing pattern, however, has been that with the cuts in Federal funding for the title V MCH block grants in 1981, the majority of States did increase State appropriations in an attempt to make up some of that gap. However, those appropriation increases in States did not tend to be sufficient to totally cover the reductions in Federal funding of the title V MCH block grant programs and the inflation and health care costs.

Moreover, starting in 1982, a number of States that had increased State appropriations for these programs, as they began being faced with financial difficulty, either cut back or found themselves in a position not to continue to increase those appropriations.

And let me just give you as an example, the title V MCH block grant programs in Colorado. In 1981, when the Federal funding for the title V MCH block grant programs was cut, the Colorado legislature increased the State funding for these programs 16 percent. However, later in the year, facing a deficit, they did an across-the-board reduction that resulted in a 22-percent loss of State funds to this program. In 1983, the legislature again increased the appropriation for these programs, but later in the year again facing a deficit, they cut the appropriation 18 percent. So that Colorado now has less State funds today than it did in 1981. And I do not think it is because the Colorado Legislature has been ungenerous. I think it is because the Colorado Legislature has found themselves in a difficult situation and just has been unable to do what they would like to do in terms of funding for these programs.

And that kind of story is pretty typical of what has been happening with State funding in the States for the last 2 years.

Now I would like to emphasize that a really terrible problem for the title V MCH block grant programs in the State is the inflation in health care costs, particularly hospital costs, which they have little or no control of. The State crippled children's programs have been particularly hard hit. They have been particularly hard hit because they deal with children that need more than average in the way of health care, particularly hospital care, highly specialized care, very expensive care.

We are finding that those programs are having to cope with inflation in overall hospital costs of anywhere from 12 to 36 percent. Moreover, when you look at individual components of the program—that is, tertiary hospital care for children that have very serious——

Senator BENTSEN. Ms. Gittler, I am going to have to ask you to summarize, please.

Ms. GITTLER. OK; they are even more harder hit. You have heard something about the emergency jobs bill money and I just would like to say that I have a report here on what is being done with the jobs bill money that I would like to submit for the record.[1]

Senator Bumpers told you what is being done with that money in Arkansas and I think that that is a typical kind of story.

And finally, I would like to say that even with the emergency jobs bill money, States are having difficulty meeting all the needs that they are supposed to be meeting. And let me just give you one example that I think points up this problem.

In Arizona, the jobs bill money is being used to establish basic prenatal screening and care for low-income women. They are going to serve about 500 women a year. They estimate that that is only 10 percent of the unmet need in the State. So the emergency jobs bill money is helping a great deal, but there is a long way to go.

Thank you.

[The prepared statement of Ms. Gittler follows:]

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[1] The report submitted for the record may be found in the subcommittee's files.

PREPARED STATEMENT OF JOSEPHINE GITTLER

Mr. Chairman, I appreciate the opportunity to appear before you to testify on behalf of the National Maternal and Child Health Resource Center regarding the funding of the Title V Maternal and Child Health Block Grant (MCH Block Grant) programs. The National Maternal and Child Health Resource Center is a non-profit corporation which has as one of its major objectives the collection, analysis and dissemination of information concerning federal/state maternal and child health programs. The Resource Center has conducted surveys in all fifty states and the District of Columbia to ascertain the sources and level of funding for MCH block grant programs and the adequacy of funding for these programs.

I. DESCRIPTION OF MCH BLOCK GRANT PROGRAMS

Title V of the Social Security Act, which was enacted in 1934 and provided federal assistance to the states for a Maternal and Child Health Program for low-income mothers and children and a Crippled Children's program for children with handicapping conditions or potentially handicapping conditions.

The Title V Maternal and Child Health Block Grant (MCH Block Grant) legislation, enacted in 1981, consolidated the Title V Maternal and Child Health program and the Title V Crippled Children's programs with the following programs: the Supplemental Security Income for Blind and Disabled Children, the Lead Poisoning Prevention Program, the Sudden Infant Death Syndrome Program, the Genetic Diseases Program, and the Hemophilia Diagnostic and Treatment Center Program.

At the state level the Title V MCH Block Grant programs are public health programs designed to improve the health status of all mothers and children by promoting an optimal health care delivery system for mothers and children. The state agencies which administer the MCH Block Grant programs perform several functions, including planning, coordination of existing services, introduction of innovative methods of health care into the health care delivery system, training and education of health professionals, and the provision of direct services and outreach services.

The MCH Block Grant programs have a strong preventive thrust, and a number of studies have found them to be cost-effective and highly successful in improving the general health of mothers and children, in reducing infant mortality and morbidity, and in reducing handicapping conditions and serious illness and their complications.

The MCH Block Grant legislation gives states a great deal of flexibility in determining what services shall be funded and how these services will be provided. At the same time, the legislation requires state agencies administering the Block Grant to prepare and to submit to the Secretary of the Department of Health and Human Services a detailed maternal and child health plan called "a report of intended expenditures" and contains other requirements designed to promote accountability.

The legislation also recognizes that the federal government has a leadership role to play vis-a-vis the states in improving the health status of mothers and children and mandates the maintenance of "an identifiable administrative unit with expertise in maternal and child

health within the Department of Health and Human Services" to carry out various designated activities with respect to maternal and child health.

Under the MCH Block Grant legislation, 85 percent of the appropriation for the Block Grant is allocated to the states, based upon a formula, for maternal and child health services. The remaining 15 percent of the appropriation is "set-aside" for discretionary grants for maternal and child health projects of regional and national significance, regional hemophilia centers, genetic diseases projects, and applied research and training in the area of maternal and child health by the Federal Office of Maternal and Child Health.

II. STATUS OF FEDERAL FUNDING OF MCH BLOCK GRANT PROGRAMS

In federal fiscal year 1981 the total federal appropriation for the programs subsequently consolidated in the MCH Block Grant was $456,896,882. The MCH Block Grant legislation enacted in 1981 provided an authorized funding level for the MCH Block Grant of $373 million which represented an overall cut of 18% in funds available for MCH Block Grant programs, and it represented a much greater cut of about 38% in the funds available for discretionary grants for Special Projects of Regional and National Significance supported with the 15% of the MCH Block Grant appropriation "set-aside" for this purpose.

The FY 1983 appropriation for the MCH Block Grant was $373 million. In addition there was a special appropriation of $105 million under Public Law 98-8, the Emergency Jobs Bill. Thus, the total FY 1983

appropriation for the MCH Block Grant was $478 million. The FY 1984 appropriation for the MCH Block Grant is $399 million, which represents a cut in funding of $79 million. It should be noted that the authorization level of the Block Grant has remained at $373 million.

Since the creation of the MCH Block Grant in 1981, federal funding of MCH Block Grant programs has not even kept pace with general price inflation. The FY 1984 constant service level for the MCH Block Grant is $607,252,000 based on the FY 1980 appropriation assuming maintenance of real purchasing power. This funding level is $234 million more than the current authorization level of $373 million and $208 million more than the current appropriation of $399 million.

It must also be emphasized that even prior to the creation of the MCH Block Grant in 1981 and the accompanying reduction in federal funding of MCH Block Grant programs, federal funding of the programs consolidated in the Block Grant had not kept pace with inflation. Thus, the purchasing power of the FY 1981 federal appropriation for the Title V Maternal and Child program and Crippled Children's program was actually 27% less than FY 1972 federal appropriation for these programs.

III. CUMULATIVE EFFECT OF REDUCTIONS IN FEDERAL FUNDING OF MUCH BLOCK GRANT PROGRAMS AND LOSS OF OTHER FEDERAL FUNDS

While the total federal appropriation for the MCH Block Grant increased from 1982 to 1984, it is important to bear in mind the inter-relationship between the 85% of the Block Grant appropriation which goes to the states on the basis of a formula and the 15% of the Block Grant appropriation which is set aside for discretionary grants for the regional hemophilia centers program, the genetics projects and projects of regional and national significance. As it has been pointed out, set aside funds were more severely reduced than formula funds, and a significant number of states have relied upon discretionary set aside grants for major components of their maternal and child health care system. Furthermore, in many states the reduction in federal funding for MCH Block Grant programs has been compounded by the loss of federal funding from other health and human services categorical and human service programs which was being utilized to support maternal and child health and crippled children's services.

- In Alabama in FY 1981 the maternal and child health program received $7.4 million in federal funds. The sources of these funds were the Title V Maternal and Child Health program formula funds and severe discretionary grants, the Genetics Diseases program and the Sudden Infant Death Syndrome program which were subsequently incorporated in the MCH Block Grant, the Community Health Center Program, the Appalacian Regional Commission and the National Health Service Corps program. In FY 1983 the maternal and child health program received approximately $6 million in federal funds. This reduction of approximately $1.4 million in federal funds was due to the loss of several Title V maternal and child discretionary grants, the loss of discretionary grants from other programs consolidated in the MCH Block Grant, the loss of Appalachian Regional Commission funding and the loss of National Health Service Corps assignees.

The MCH Block Grant programs have also been negatively affected by reduction in funding of the Title XIX Medicaid program which provides federal reimbursement to the states for a proportion of medical care and expenditures for low-income individuals including mothers and children enrolled in the program. The MCH Block Grant programs provide services to a substantial number of mothers and children who are not eligible for the Medicaid program, but who do not have the private health insurance coverage or the personal financial resources necessary to obtain needed care, and the MCH Block Grant programs provide services to a substantial number of women and children who are eligible for Medicaid program but who need care not covered by the Medicaid program.

At the state level federal Medicaid funding reductions have been translated into more stringent eligibility requirements for the Medicaid program and more stringent limitations on the scope of coverage under the Medicaid program, and both of these developments have affected reimbursement available under this program for needed health care for low-income pregnant women and children. As a result an increasing number of women and children have turned to the MCH Block Grant programs for services and financial assistance at the very time when these programs have had to absorb their own federal funding cuts.

IV. STATUS OF STATE FUNDING OF MCH BLOCK GRANT PROGRAMS

State funding of MCH Block Grant programs varies considerably from state to state. In some states there is no state appropriation or only a minimal state appropriation for these programs which consequently are

very dependent on federal MCH Block Grant funds. (In such states the requirement that states match federal MCH Block Grant formula funds received may be satisfied by state in-kind contributions, local funds, and funds and in-kind contributions from contractors). In other states these programs are heavily state funded, and the federal MCH Block Grant funds constitute only a small proportion of total program budgets. In still other states these programs receive substantial state funding.

Just as the level of state funding of MCH Block Grant programs has varied, the responses of the states to reductions in federal funding of MCH Block Grant programs has varied. In 1981-82 the most typical pattern was for states to increase state funding of MCH Block Grant programs, although such increases in state funding were generally not sufficient to make up for the effects of the federal funding reductions and inflation. During the period 1982-84, however, many states began to experience financial difficulties, and as a result in the majority of states, these programs received little or no increases in state funding and in some states, state funding was actually reduced.

- In Colorado the FY 1981-82 state appropriation for the Maternal and Child Health program and the Crippled Children's program was $3,043,840. The FY 1982-83 state appropriation for these programs was increased 16% to $3,534,979 in order to offset the cut in federal funding for the MCH Block Grant programs. When, however, later in the year the state encountered fiscal difficulties, this appropriation was cut 22%. The FY 1983-84 state appropriation for these programs was $3,498,000. Faced with a possible state deficit, however, this appropriation was subsequently cut 16%. Thus the 1983-84 state appropriation was below the 1981-82 appropriation.

V. IMPACT OF INFLATION IN HEALTH CARE COSTS ON MCH BLOCK GRANT PROGRAMS

As it has been pointed out, federal funding and in most cases, state funding of MCH Block Grant programs has not kept pace with inflation in health care costs. In recent years inflation and these costs have exceeded inflation as measured by the Consumer Price Index, and the MCH Block Grant programs essentially have little or no control over these costs.

The state Crippled Children's programs, which have traditionally provided or purchased in-patient hospital services, out-patient services and support services for children with handicaps and chronic or life-threatening illness, have been particularly hard hit by the inflation in health care costs, especially hospital costs.

It should be noted at the outset that many families with disabled and seriously ill children rely on the state crippled children's programs for financial assistance in meeting the needs of these children. Many of these children lack private insurance coverage, and when private insurance coverage does not exist for such problems, it is often deficient from the standpoint of services covered. Although the Title XIX Medicaid problem has made a major contribution to the care of these children, and the scope of Medicaid coverage is limited.

Furthermore disabled and seriously ill children require more in-patient hospital and out-patient care than other children, and the cost of such

care, which is specialized in nature and tends to extend over long periods of time, is high. In addition the care of this population involves non-medical costs for items such as child care, transportation for visits to service providers, and a variety of support services.

There have been large increases in the cost of in-patient hospital care for children enrolled in state Crippled Children's programs due to the inflation in the cost of this care.

- The Louisiana Crippled Children's program has been faced with an increase of 34% in the overall (per-diem) cost of in-patient hospital care for children enrolled in the program. Even greater increases have occurred in the cost of in-patient care in hospitals which the program utilizes for certain types of specialized care. Thus, in May 1983 there was an increase of $244 in the cost of in-patient care for children receiving services in the Tulane University Hospital which the crippled children's program utilizes for tertiary care of children with cardiac and pulmonary problems.

- The Texas Crippled Children's program has been faced with an increase of 15.6% in the overall (per-diem) cost of in-patient hospital care for children enrolled in the program.

While the increases in the cost of out-patient care for children enrolled in state crippled children's programs has not been as dramatic as the increase in the cost of in-patient hospital care for these children, the rise in out-patient costs has nevertheless been substantial for many programs.

- In Oregon the average cost of out-patient clinic services for a child enrolled in the program increased $250, or 46%, from 1980-81 to 1982-83.

- In Florida the average cost of outpatient care clinic services for a child enrolled in the program increased $73.08, or 16%, from 1980-81 to 1982-83.

Although many state Crippled Children's programs have been forced to curtail their assistance to disabled and seriously ill children, service

reductions would have been even more severe but for the fact that private physicians and other health professionals who work in these programs have contributed their services free or receive reimbursement at rates below their normal reimbursement rates.

- In Louisiana, the Crippled Children's program pays 200 physicians only $300 a month to hold an average of 2 diagnostic and treatment clinics per month and if a child must be hospitalized, these physicians do not charge the program for surgical and medical care during hospitalization and receive payment only if other third party reimbursement is available.

- In New Mexico the existing reimbursement rates for physicians and other health professionals are the same as were established in 1976 and have not been increased despite the inflation in health costs since 1976.

The inflation in health care costs has also negatively affected the state Maternal and Child Health programs. Thus, state Maternal and Child Health programs which pay for needed in-patient hospital care for pregnant women and seriously ill newborns have been confronted with financial problems due to inflation in health care costs comparable to the already described problems of the state crippled children's programs.

VI. IMPACT OF POOR ECONOMIC CONDITIONS AND HIGH UNEMPLOYMENT

Even before cuts in federal funding in the MCH Block Grant Programs were made in 1981, these programs were not able to provide services to many mothers and children they were mandated to serve because of inadequate funding. The inability of MCH Block Grant programs to meet the demand

for services increased as economic conditions worsened and unemployment rose. With the high rate of unemployment, more and more families have found themselves without private health insurance coverage and unable to purchase care in the private sector, and therefore, they have turned to public programs like the MCH Block Grant Programs.

Since 1981, there has been a substantial increase in demand for public health services supported by state Maternal and Child Health programs with MCH Block Grant funds that appears to be attributable at least to some extent to high unemployment, and this demand appears to be continuing. The following examples are illustrative:

- In Alabama there have been substantial increases in the active caseloads of public maternity clinics supported with MCH Block Grant funds from 1981 to 1983. In Mobile County, the active caseload increased approximately 21%; in Madison County, approximately 20%; and in Tuscaloosa County, approximately 17% during this period. All of these counties have high unemployment and pregnant women are applying for services, who previously obtained services from private providers but who cannot continue to do so because of loss or lack of insurance due to unemployment.

- In Louisiana there was an increase of 34% in the caseload of the prenatal clinics supported with MCH Block Grant funds in 53 of 64 parishes from 1981 to 1982 and the demand for these services has continued to grow in 1983. Similarly over two-thirds of the parishes experienced an increase in child health patients from 1981 to 1982 and the number of patient encounters rose 8% in 1983 as compared to 1982.

- In New York City, the Maternity and Infant Care Project supported with MCH Block Grant funds had to turn away 1,000 applicants (mothers and infants) for services in 1982 due to lack of funds, and the MIC project had to turn away about 400 applicants (mothers and infants) for services in the first six months of 1983 due to lack of funding.

- In Kansas City, Kansas the number of pregnant women served in prenatal clinics, supported with MCH Block Grant funds, increased 22% from 1981 to 1982, and the monthly caseload in the children and youth project, supported with MCH Block Grant funds, increased 16%.

State Maternal and Child Health programs have also experienced changes in the make-up of their caseloads. A higher percentage of mothers and children served by these programs are uninsured. This has meant that these programs are having to assume all or almost all of the costs of care for an increasing number of mothers and children.

- A 1983 survey of 14 Massachusetts health agencies which receive MCH Block Grant funds to provide primary prenatal and pediatric care found that nine of these agencies had experienced increases in the percentage of uninsured mothers and children with the average increase being about 6%. This increase in the percentage of the caseload without insurance appeared to be linked to loss of Medicaid benefits due to changes in AFDC eligibility and loss of private group insurance benefits or ability to purchase care because of unemployment.

The State Crippled Children's programs which utilize MCH Block Grant funds for services for children with handicapping conditions or potentially handicapping conditions and chronic diseases also reports a substantial rise in applicants and referrals that appears to be at least partially associated with high unemployment. The following examples are illustrative:

- In Illinois, the proportion of families of children enrolled in the Crippled Children's program with no insurance has risen from 39% in FY 1981 to 43% in FY 1983. A random sample of active 1983 cases indicated that there was family unemployment in 10.5% of the cases. A random sample of active 1983 cases in four areas of high unemployment indicated that there was family unemployment in 31% of the cases.

- In Ohio the Crippled Children's program experienced an increase of new applications of 18.5% from 1982 to 1983.

- In Maryland, a random sample of applications to the Crippled Children's program in the first six months of 1982 and the first six months of 1983 revealed the following:

The percentage of unemployed Crippled Children's program applicants where there was unemployment has increased 9% from the first 6 months of FY 1982 to the first 6 months of FY 1983. It went from 31% in 1982 to 40% in 1983. The percentage of Crippled Children's program applicants where there was insurance coverage has decreased 10% during the same comparison period. It went from 36% in 1982 to 26% in 1983. The percentage of applicants that the Crippled Children's program is now assuming full financial responsibility for has increased 14% during the same comparison period. It went from 58% in 1982 to 72% in 1983.

While employment in Maryland has been fairly stable, but the Crippled Children's program is receiving applications from families who need financial assistance because they have lost employment and are losing insurance benefits.

- The West Virginia Crippled Children's program experienced a 40% increase in the number of applicants and referrals in January 1983, as compared to January 1982. A random sample of newly authorized cases processed in January 1983 revealed that 22.6% of the children's families were unemployed whereas a random sample of cases processed in July--December 1982 revealed that 15.75% of the children's families were unemployed.

An increasing number of children enrolled in state Crippled Children's programs also have no public or private third party coverage and lack the financial resources to pay for care. Hence, the expenditures of these programs for enrolled children are rising.

- The Ohio Crippled Children's program experienced an overall increase of 50% in the number of children enrolled in the program who had neither Medicaid nor private health insurance during 1982-1983. Thus, in 1982, 26.9% of the children with hyline membrane disease had no third-party coverage; but in 1983, 33% had no third-party coverage; and as a result, the expenditure of the program for these children rose an estimated $330,000.

VII. SUPPLEMENTAL FEDERAL APPROPRIATION FOR THE MCH BLOCK GRANT PROGRAMS UNDER THE EMERGENCY JOBS BILL (P.L. 98-8)

In the spring of 1982 the Emergency Jobs Bill legislation was enacted which provided a supplemental appropriation of $105 million for the MCH Block Grant programs. In most states, some form of legislative approval had to be obtained before the agencies administrating the MCH Block programs could obligate and expend these funds and avert the necessity of obtaining legislative approval. Many states could not start this process until mid or late summer of 1983. At the present time 82% of the Emergency Jobs Bill funds received by the states have been obligated.

The National Maternal and Child Health Resource Center has conducted a 50 state survey which indicates that the state Maternal and Child Health programs are using emergency jobs bill funds primarily to provide prenatal care, maternity care and newborn care. Most of the state Crippled Children's programs are using these funds to pay for in-patient hospital care and out-patient services for disabled and seriously ill children.

In a significant number of states, state Maternal and Child Health and state Crippled Children's programs have to use Emergency Jobs Bill funds to restore cuts in programs that were previously made due to inadequate funding. Likewise in a significant number of states these programs are using these funds to make up anticipated program deficits and to

maintain the existing level of services. In almost all states, however, the Emergency Jobs Bill funds will also enable the state Maternal and Child Health and Crippled Children's programs to expand and increase services.

- In Alaska, the Crippled Children's program was so low on funds by June 1983, that only emergency life-saving care could be authorized, and emergency jobs bill funds are being used to supplement the budget of the Crippled Children's program.

- In Ohio, the state which has the third highest unemployment rate in the nation, the Emergency Jobs Bill funds are being used to do the following: The Crippled Children's program will serve 3,649 more children in 1983-1984 than in 1982-1983. The Maternal and Child Health program will conduct maternity and child health clinics in 15 counties, which currently do not have clinic services, and this will mean that approximately 3,000 more pregnant women will receive services and approximately 1,500-2,000 more infants and children will receive services. The dental program will serve an estimated 200,000 more children in 11 counties. The lead based poisoning prevention program will expand its activities.

- In Arkansas, the Emergency Jobs Bill funds are being used to do the following: The Maternal and Child Health Program will use the funds to provide care to low-income mothers and children in the eastern area of the state which now lacks prenatal and child health clinics. The services provided will include the development of short stay birthing centers. Without these funds, which are being used to develop these centers, about 500 medically indigent pregnant women would have no place to deliver. The funds are also being utilized to do more extensive screening to identify high-risk pregnancies requiring intensive care and to increase outreach and education. The Crippled Children's program will use the funds to reinstate a dental program for handicapped children which was discontinued due to lack of funds and to purchase in-patient hospital care and out-patient care for children with unemployed parents.

VIII. UNMET NEED FOR MATERNAL AND CHILD HEALTH SERVICES AND CRIPPLED CHILDREN'S SERVICES

Unless federal funding for the MCH Block Grant programs is continued at the FY 1983 funding level which included not only the regular appropriation of $373 million but also the special appropriation of $105

million under the Emergency Jobs bill, valuable maternal and child health services will once again have to be cut back.

Moreover, even if the FY 1983 funding level for the MCH Block Grant is continued, there are many maternal and child health needs which state maternal and child health programs simply cannot meet because of lack of resources.

- In Texas, 119 counties have no public maternity clinics and 93 counties have no public child health clinics. In counties which do have public maternity clinics and public child health clinics, there are frequently waiting lists of applicants. Thus, in the City of Houston and in the City of Forth Worth, there is a 6-8 week wait for the public maternity clinics supported by MCH Block Grant Funds.

- In Arizona, emergency jobs bill funds will be used to establish basic prenatal screening and care for low-income women and it is estimated that this project will provide care for about 500 women per year, but this represents only about 10 percent of the current unmet need for such services in the state.

- In South Carolina, 7,500 pregnant women received prenatal services in public maternity clinics supported with MCH Block Grant funds in 1983, but less than 40 percent of women began care during the first trimester of pregnancy, and 13 of 46 county health departments do not provide prenatal services.

- In Massachusetts, the lead poisoning prevention program will screen 148,000 children in the high-risk age group (0-6), but 250,000 children who are in need of screening will not be screened.

Just as there are many unmet maternal and child health needs, there are many unmet needs with respect to services for children with handicaps, chronic illnesses, and life-threatening illnesses. In a number of states, funding constraints have compelled the state Crippled Children's programs to significantly restrict program eligibiity in terms of income, diagnostic conditions, and age and to significantly limit the

type of services which will be provided and the length of time that services will be provided.

- In Texas, the Crippled Children's program has drastically reduced the purchase of services for ventilator-dependent children including equipment and supplies, which would permit such children to receive care at home rather than in the hospital, due to funding constraints.

- In 1983, the Illinois Crippled Children's program implemented the following cutbacks in response to decreases in funding: medical eligibility has been restricted so that certain physical impairments and some acute conditions will no longer be eligible. Financial eligibility has been redefined to focus services to families with the most limited financial needs. Hospital reimbursement is limited to necessary stays and a per child per year reimbursement amount cap has been imposed. Some assistive appliances have been eliminated, and all others are being provided on a more restrictive basis.

- In Maryland, the Crippled Children's program has a financial eligibility scale that was last revised in 1977 and it is estimated that only one-half of the Maryland families that would have been eligible for services in 1977 would still be eligible in 1982. This program has been unable to revise its financial eligibility scale because of lack of funding.

- In South Carolina, funding problems forced the Crippled Children's program to reduce the FY 1982 limit of eligibility from age 21 to 18. A child is not eligible for this program unless his/her family income is 200 percent or less of poverty regardless of family size and regardless of the child's medical condition. Children with certain medical conditions such as leukemia are not eligible for the program. In 1982, the program's caseload dropped 20 percent and the caseload in 1983 will be roughly the same as it was in 1982.

IX. CONCLUSION

MCH Block Grant programs have accomplished much, but much remains to be accomplished. These programs are currently faced with inadequate federal and state appropriations, the cumulative effect of loss of federal funds from other programs which had been used to support

maternal and child health and crippled children's services, inflation in health care costs, and an increasing demand for services. These programs do not have sufficient funding to reach large numbers of mothers and children, including disabled and seriously ill children, in need of services. Hence, they are unable to fully carry out their mission to improve the health status of mothers and children.

Senator BENTSEN. Thank you, Ms. Gittler. Dr. Salisbury, if you would proceed. I will be absent for about 5 minutes, but I will be back after looking in on the Finance Committee where I have an amendment coming up.

If you would proceed, Doctor.

STATEMENT OF ARTHUR J. SALISBURY, M.D., VICE PRESIDENT, MEDICAL SERVICES, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, WHITE PLAINS, N.Y.

Dr. SALISBURY. Since most of what I was going to say has already been said, I am just going to summarize quite briefly the various points that have been made. The 30 percent, approximately 30 percent, cut has resulted in severe reduction of services and changes in eligibility criteria for maternal and child health services. And no less than 47 States have reported such reductions.

The services that have been cut are the most basic, which are concerned primarily with the health of the next generations of Americans and all have been repeatedly demonstrated to be among the most cost effective of any type of health service.

The point has been made that the curtailment came at the worst possible time, when unemployment, loss of health insurance, income reductions were so severely impacting on people of low income in this country.

The point has been made that mounting Federal deficits are of great concern in the present and in the future. But by trying to significantly reduce the $200 billion deficit by cutting appropriations for maternal and child health which never have exceeded $450 million per year, we have, to use an unfortunate analogy, thrown the baby out with the bath water in this country since 1981.

I do want to cite some cost-effectiveness figures. These come from California, in the study of the birth data for 1980. They found that 10,000 women who receive early and regular prenatal care will produce 520 infants who weigh less than 5½ pounds. Not all of these infants will require intensive care, but those who do will have hospital bills of $4.6 million. Those are babies born to women who have early and regular prenatal care.

In contrast, 10,000 women who do not receive prenatal care will produce 1,410 babies who weigh less than 5½ pounds. The cost of intensive care for this group will be $16.8 million. The difference in intensive care cost between the no prenatal care group, $16.8 million, and the group that does receive prenatal care, $4.6 million, the difference is $12.2 million.

Now the cost of providing prenatal care to the 10,000 women in the no-care group would be $10 million, $1,000 each. Nonetheless, the net savings of $2.2 million for 10,000 women is produced.

Now we think we have 185,000 women in this country—that is the 5-percent figure mentioned earlier by Ms. Rosenbaum—who are receiving grossly inadequate prenatal care or no prenatal care. The net savings for these approximately 185,000 women each year would be $40 million yearly in intensive care costs alone. And, of course, there are other costs that are incurred.

One point that I was asked to respond to was this one. When the budget cuts became law in 1981 and proceeded through the last few fiscal years, it was frequently stated, both at the White House and

on Capitol Hill, that the voluntary and independent sector would be able to fill the gaps created by reductions in governmental funding.

Now the only voluntary agency in the country supporting the provision of prenatal and perinatal care is the March of Dimes. We do this through grants to hospitals, clinics, and health departments. These grants are seed moneys to be used to improve and expand existing services or to create new ones.

I emphasize the phrase "seed money."

The program categories included are physicians' and nurses' services, public health education, and professional education. We are able to budget approximately $7.2 million in the March of Dimes each year for grants relating to prenatal and perinatal care. If we were to do more, our activities and research on birth defects and in diagnosis, treatment, and counseling for genetic or inherited disorders would have to be curtailed. This we do not feel that we can fairly do.

If we were to devote all of our spendable resources to closing the gaps in the availability of prenatal and perinatal care, we could make only a very small dent in the problem that we have heard described.

We can fund demonstrations of new medical and educational innovation, such as our ongoing effort in prevention of preterm delivery. We can provide seed money for new ventures, but we cannot pay yearly clinic, hospital, and physician bills for 185,000 grossly underserved pregnant women.

In closing, I do want to mention that the March of Dimes firmly stands behind and endorses the action in the House and in the Senate to increase the ceiling authorization for the maternal and child health block grant. The problem of loss of the jobs bill money has been mentioned and we certainly feel that this represents essentially a cut in the current fiscal year 1984 appropriation, which is now $399 million, but this is less than the jobs bill supplement provided last year.

There has been an increase, I understand, with some action perhaps taken last night in the Reconciliation Act budget, and this is an increase in the level for the MCH block grant which we heartily applaud.

I also want to mention or reinforce the mention of the bill introduced by Congressman Waxman in the House which would expand medicaid coverage for poor pregnant women and their infants who are now excluded. These women include those pregnant for the first time, those in low-income families where the primary wage earner is unemployed, and, beginning in 1986, women in all low-income two-parent families.

The unique part of this bill perhaps is that it would provide 100-percent Federal reimbursement to the States for the cost of their expanded coverage.

Senator BENTSEN. That is what I did in the Finance Committee over here on the Senate side.

Dr. SALISBURY. Also on the Senate side, yes. Senator Cranston, and you were involved in that action. We certainly endorse the extension of medicaid coverage.

The savings in total costs are certainly important, but lack of prenatal care probably contributes to approximately 20,000 deaths in newborns each year. Many more survive, but are permanently damaged. We should not allow financial barriers to obtaining prenatal care by the poor be a cause of these losses.

Thank you, Senator.

[The prepared statement of Dr. Salisbury follows:]

Prepared Statement of Arthur J. Salisbury, M.D.

I am Dr. Arthur J. Salisbury, the Vice President for Medical Services of the March of Dimes Birth Defects Foundation. As you know, the March of Dimes now devotes its energies and resources to the prevention of birth defects and of other tragic outcomes of pregnancy. I have been asked to comment today on the adequacy of federal funding of maternal and child health services and on the effects of changes in this funding which have been made in recent years.

The Omnibus Budget Reconciliation Act of 1981 created the Maternal and Child Health Block Grant to the states. Seven previously categorical programs were absorbed into the block and the overall level of funding was reduced by approximately 30 percent. Quite predictably, these cuts have forced the states to reduce the extent of services previously provided and to change eligibility criteria reducing the number of mothers and children who can receive the services. No less than 47 states have reported such reductions.

The services which have been cut back or eliminated include prenatal and delivery care, health supervision and preventive services for children, treatment of chronic, disabling conditions of childhood and family planning services. All of these have been repeatedly demonstrated to be among the most cost effective of all health and medical services.

The curtailment of services came at the worst possible time. Unemployment and underemployment with attendant loss of health insurance benefits forced families to seek publicly supported care for which they had previously been able to pay. And they found that clinics had been closed or were unable to take any more patients because of reductions in funding.

Mounting federal deficits present critical prospects now and for the future, but in trying to significantly reduce a 200 billion dollar deficit by cutting appropriations for maternal and child health, which never have exceeded 450 million dollars per year, we have to use an unfortunate analogy, throw the baby out with the bath water.

We know that maternal and child health services are effective in reducing overall and long term costs. I will give just one example. I have drawn on birth data for 1980 studied in California.

Ten thousand women who receive early and regular prenatal care will produce 520 infants who weigh less than 5½ pounds (2500 gms). Not all of the infants will require intensive care, but those who do will have hospital bills of $4.6 million.

Ten thousand women who do <u>not</u> receive prenatal care will produce 1,410 babies who weigh less than 5½ pounds. The costs of intensive care for this group will be $16.8 million. The difference in intensive care cost between the no prenatal care group ($16.8 million) and the group receiving prenatal care ($4.6 million) is $12.2 million. The cost of providing prenatal care to the 10,000 women in the <u>no</u> care group would be $10.0 million ($1,000 each) producing a net savings of $2.2 million for 10,000 women.

The net savings for the approximately 185,000 (5 percent) women now receiving inadequate or no prenatal care would be $40.7 million yearly in intensive care costs alone.

When the Omnibus Budget Reconciliation Act became law in 1981, it was frequently stated, at the White House and on Capitol Hill, that the voluntary and independent sector would be able to fill the gaps created by reductions in governmental funding. The only voluntary agency supporting the provision of prenatal and perinatal care is the March of Dimes. We do this through grants to hospitals, clinics and health departments. These grants are seed monies to be used to improve and expand existing services or to create new ones. The program categories included are physicians and nurses services, patient education and professional education. We are able to budget approximately $7.2 million per year for grants relating to prenatal and perinatal care. If we were to do more, our activities in research on birth defects and in diagnosis, treatment and counseling for genetic or inherited disorders would have to be curtailed. If we were to devote all of our spendable resources to closing the gaps in the availability of prenatal and perinatal care, we could make only a very small dent in the problem. We can fund demonstrations of new medical and educational innovations, such as our new ongoing effort in prevention of preterm delivery. We can provide seed money for new ventures, but we cannot pay yearly clinc, hospital and physician bills for 185,000 grossly underserved pregnant women.

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What has been done and what can be done about this and other major problems created by cutting federal expenditures for maternal and child health services?

In recent weeks, the Congress has passed and the President has signed the Labor, Health and Human Services Appropriations Act for fiscal year 1984. This Act includes the amount of $399.0 million for the Maternal and Child Health Block Grant. In 1983, the amount for the Block Grant was $373.0 million, but this was increased by $105.0 million to $478.0 million by supplements contained in the Jobs Bill. We can, therefore, say that the appropriation has been increased by $26.0 million or, since the funds in the Jobs Bill are not available in fiscal year 1984, we can say that the appropriation has been decreased by $89.0 million. I prefer to interpret the 1984 amount as an increase because it is a step in the right direction.

Another step is currently before the Congress. Senator Bumpers, in association with Senators Bentsen, Heinz, Matsunaga, Moynihan and Cranston, has introduced a bill which would increase the level of funding authorized for the Maternal and Child Health Block Grant to $499.5 million for fiscal year 1984. Such an increase would remove the current ceiling on the appropriation level and this would make significant increases in the amounts going to the states for the maintenance and reinstitution of services which have been curtailed or eliminated. We urge passage of Senator Bumpers' bill which is S. 2013.

Another important bill has been introduced in the House by Congressman Waxman. This bill would expand Medicaid coverage for poor pregnant women and their infants who are now excluded. These women include those pregnant for the first time, those in low income families where the primary wage earner is unemployed and, beginning in 1986, women in all low income two parent families. Mr. Waxman's bill would provide 100 percent federal reimbursement to the states for the cost of this expanded coverage. The states would utilize their own income and asset standards for determining eligibility as impoverished.

Senator Cranston has introduced an amendment to the Budget Resolution which would provide similar expansion of coverage under Medicaid for poor pregnant women.

The March of Dimes has endorsed both bills because they would remove, in part, the financial barrier to obtaining prenatal care which now confronts poor women.

I have already discussed the savings in total costs which are possible if women receive prenatal care. Lack of prenatal care probably contributes to approximately 20,000 deaths of newborns each year. Many more survive, but are permanently damaged. We should not allow financial barriers to obtaining prenatal care by the poor be a cause of these losses.

Extending Medicaid coverage to poor pregnant women and increasing the authorization and appropriations for the Maternal and Child Health Block Grant will be significant steps in improving the availability and accessibility of prenatal care.

Senator BENTSEN. Dr. Salisbury, my son's work with the March of Dimes and attention to the concerns of prenatal care is probably what first got me seriously interested in understanding how serious the need is for better prenatal care and how important it is that we do what we can in that regard.

Dr. SALISBURY. Well, I know Len very well and we certainly appreciate his great help to us in Houston.

Senator BENTSEN. Thank you. Dr. Osgood, please proceed.

STATEMENT OF KENNETH OSGOOD, M.D., LAS VEGAS, N. MEX., REPRESENTING THE AMERICAN ACADEMY OF PEDIATRICS

Dr. OSGOOD. Thank you, Mr. Chairman. Since the enactment of the maternal and child health block grants, the American Academy of Pediatrics has reviewed articles, studies, and reports on maternal and child health. The questions addressed in these studies relate to the impact of Federal regulatory changes—can you hear me now? I am sorry.

Mr. Chairman, since the enactment of the block grant concept in 1981, the American Academy of Pediatrics has reviewed some 20 articles, studies and reports on the maternal and child health block grant. The questions addressed in these studies relate to the impact of the Federal regulatory changes, to the Federal funds cuts, and to how States respond to the new flexibility reflected in the law.

To summarize, the studies have found that when compared to the last years of the categorical grant system with the first year of the maternal and child health block grant system, few States have changed the types of programs offered. Most States have initiated new restrictive eligibility requirements and/or reduced services, programs with statewide emphasis, ones historically having State fiscal participating, and those with a very vocal constituency continue to receive support under the block grants. Most States have made across-the-board funding cuts in all programs; most States have not added State money to replace lost Federal money; and, some States have used carryover funds from the previous years to lessen the impact of the Federal budget cuts.

Mr. Chairman, the block grants are designed to allow greater flexibility in targeting populations and prioritizing needs. However, given the short time States have had to implement the blocks, few program changes have yet been made.

In my own State of New Mexico, a statewide, community-based case management system has recently been initiated using the block grant funds. This system was developed to more efficiently integrate persons in need with the appropriate health services. The flexibility rendered States in the block grant concept enabled this program to be implemented. However the severe budget cut restraints mentioned by all of the people on the panel and by yourself have jeopardized its survival and the opportunity to demonstrate effectiveness in improving access to service, efficiency of service delivery, and ultimate cost effectiveness.

Next year, we can anticipate program changes in many States, since by then they will have had an opportunity to develop their own priorities. Preliminary information seems to indicate that States will favor broadly targeted programs and those historically receiving State

funds. It appears that other programs focusing on sudden infant death syndrome, genetics, hemophilia, and lead-based poisoning are programs designed to meet the needs of the inner-city poor may not fare as well.

An example of an inner-city program being compromised occurs in New York City's Manhattan Borough where this year, a maternal and child health funded children and youth clinic serving 6,000 children had to be closed because of lack of funds. Prior to this closure, in New York City, 98,000 children and women in need of services were receiving funds either through various forms of the maternal and infant care projects and children and youth projects funded by the block grant.

A 1982 study on the impact of these New York City programs indicates that a $9 million public expenditure to fund these programs resulted in approximately a $21 million cost savings. This study implies a savings of approximately $12 million to the taxpayers during 1982. Also, this population was observed to show a decrease in its infant mortality rate, indicating that the programs were effective in improving the health status of these people.

Mr. Chairman, through your leadership and persistence, you are probing to the answers to simple questions of what has been the impact of the budgetary cuts on the MCH block grant. And by your actions, you stand ready to correct any compromising situation, whatever those situations may be. We of the American Academy of Pediatrics applaud your efforts to increase the funding level for this block grant for the short term. Evidence indicates that such an action is essential. But perhaps initiatives to create a Federal structural change, such as suggested in your Resolution 237, will give us and Congress flexible and appropriate child health policy and strategy for the long term.

We welcome the opportunity to present testimony on the maternal and child health programs, particularly since Congress has not reviewed these programs in detail since the late 1960's.

Child health cannot be viewed in a vacuum. Congress must review in detail its myriad of patchwork programs constituting child health policy and to determine their efficiency and effectiveness.

Mr. Chairman, the ultimate goal of all health programs, Federal or private, should be for the programs to deliver to mothers and children as good a quality service as possible. The programs should also be designed to maximize access to the persons in need, maximize the efficiency in the delivery of the services, and to accomplish these goals in a cost effective manner.

We of the American Academy of Pediatrics stand ready to assist you in this pursuit.

Thank you.

[The prepared statement of Dr. Osgood follows:]

PREPARED STATEMENT OF KENNETH OSGOOD, M.D.

Mr. Chairman, I am Kenneth Osgood, a pediatrician in private practice in Las Vegas, New Mexico. I am here today representing the American Academy of Pediatrics, the professional association of some 25,000 physicians in this country who specialize in the health care of children, adolescents and young adults.

As enacted in 1981, the "Omnibus Budget Reconciliation Act" (P.L. 97-35) authorized the consolidation of 21 categorical health programs into four health blocks: 1) the preventive health and health services block grant; 2) the alcohol, drug abuse and mental health block grant; 3) the primary health care block grant; and 4) the maternal and child health block grant, the lattermost being the subject of today's hearing.

Programs in the maternal and child health (MCH) block grant provide grants to states to assure that mothers and children (particularly those with low income or with limited availability to health services) have access to quality maternal and child health services. Efforts are directed at reducing the infant mortality and the incidence of handicapping conditions, such as mental retardation from lead-based poisoning; at providing preventive services such as immunizations and health assessments for low-income children; at quality prenatal, delivery and post-partum services, at rehabilitation services for blind and disabled children eligible for supplementary security income and at research in

the areas of sudden infant death syndrome, hemophilia and other genetic diseases.

Since enactment, the American Academy of Pediatrics has reviewed some 20 articles, studies and reports on the maternal and child health block grant. The questions addressed in these studies relate to the impact of the federal regulatory changes, to the federal funding cuts, and to how states respond to the new flexibility reflected in the law. To summarize, the studies have found that when comparing the last year of the categorical grant system with the first year of the maternal and child health block grant:

- Few states have changed the types of programs offered;

- Most states have initiated new restrictive eligibility requirements and/or reduced services;

- Programs with a statewide emphasis, ones historically having state fiscal participation, and those with a vocal constituency continue to receive support under the block grants;

- Most states have made across-the-board funding cuts in all programs;

- Most states have not added state money to replace lost federal money;

- Some states have used carry-over funds from the previous year to lessen the impact of the federal budget cuts.

To assess the impact of budgetary cuts on the maternal and child health programs, I address my comments below to three specific areas: 1) the actual budget cuts and the funding status; 2) the effect of these budget cuts on maternal and child health services; and 3) recommendations for your consideration to improve the maternal and child health block grant program.

BUDGET CUTS AND FUNDING STATUS

According to a recent editorial in the New York Times, "It is dawning on us from what the President's theorists say and what his budget would do, that one group of people is systematically left out of the [safety] net: children. Pick a program that benefits children, at any stage of childhood; almost certainly it is being cut severely or eliminated." If indeed a federal budget is a reflection of this nation's priorities, mothers and children rank shamefully low. When you compare the FY83 and FY84 funding levels requested by this

administration for each of the four health blocks with the FY81 aggregate funding for their respective categorical programs, reductions range from 8.5 percent to 18 percent, with the maternal and child health block shouldering the largest cut.

In FY81, the total appropriation for the programs consolidated into the maternal and child health block grant was $456,896,882. Just to stay even, adjustments for inflation using the Consumer Price Index (CPI) would add an additional 10.4 percent increase for 1981, a 6.1 percent increase for 1982 and a 4 percent increase for 1983, for a total funding figure of $556,590,758. Bear in mind this increase is based solely on the CPI and does not reflect the increased cost in medical care, which amounted to 11.6 percent between 1981 and 1982. For fiscal year 1984, Congress has funded the maternal and child health block grant at $399 million, or a 28 percent reduction in funding had the programs remained categorical (including an inflation factor). Specifically for FY84, maternal and child health was increased by $26 million or 6.9 percent. However, if one takes into account the special supplemental funding of $105 million for FY83, the FY84 appropriation for maternal and child health was decreased by $79 million, or 16.5 percent, the largest cut in funding for all the health block grants.

Most states,in my judgment, will not or cannot supplement lost federal monies with state funds. A few, such as Florida, have attempted to shift costs to Medicaid. Some states have taken advantage of their ability to shift funds from one block grant to another, to make up for shortfalls in the maternal and child health budget.

In my opinion, the full impact of the budget cuts has yet to be experienced. Nine states have been able to use carry-over funds from the previous year to minimize the impact of the budget cuts. Since this money will not be available in subsequent years, more program cuts can be expected due to budget constraints.

But what do these cutbacks mean for the programs and the population they serve?

IMPACT ON MATERNAL AND CHILD HEALTH SERVICES

The block grants are designed to allow greater flexibility in targeting populations and prioritizing needs. However, given the short time states have had to implement the blocks, few program changes yet have been made. In my own state of New Mexico, a statewide community-based "case-management system" has recently been initiated using block-grant funds. This system was developed to more efficiently integrate persons in need of appropriate health services. The flexibility rendered

states in the block-grant concept enabled this program to be implemented in New Mexico. However, the severe budget restraints mentioned above jeopardize its survival and our opportunity to demonstrate effectiveness in improving access to services, efficiency of service delivery and ultimate cost-effectiveness.

We can anticipate program changes in many states, since by then they will have had an opportunity to develop their own priorities. Preliminary information seems to indicate that states will favor broadly targeted programs and those historically receiving state funds. It appears that Crippled Children's services will receive a large share of maternal and child health funds because it is an older, statewide program with a vocal constituency.

Most states list services for crippled children as a top priority. It appears that other programs focusing on sudden infant death syndrome, genetics, hemophilia and lead-paint poisoning, or programs designed to meet needs of the inner-city poor may not fare as well. An example of an inner-city program being compromised occurs in New York City's Manhattan burrough where this year a maternal and child health-funded children and youth clinic serving 6,000 persons had to be closed because of a lack of funds. Prior to this closure, 98,000 children and women in need were served by maternal and

child health funded children and youth clinics and maternity and infant care programs. A 1982 study of the impact of these cuts indicates that the $9 million public expenditure to fund these programs resulted in a $21 million cost savings because of decreased hospitalization needs and decreased pharmacy needs of the population served. This study implies a savings of $12 million to the tax payer during 1982. Also, this population was observed to show a decrease in its infant mortality rate, indicating that the programs were effective in improving the health status of these people.

Even though the studies show that in most states the same services are being provided, people in need of maternal and child health services will not receive them. Forty-seven states have reported cutbacks either in services, eligibility, or both. Also some states have imposed fees. States are also experiencing an increased demand for services under the maternal and child health block grant. This derives from a decrease in Medicaid funding and services and from loss of private health insurance due to unemployment. Maternal and child health directors report seeing more referrals for the "near" poor, as much as a sixfold increase in some areas. Please keep in mind that this block grant was not designed to provide services to all eligible mothers and children. At a funding level just under $400 million, that only comes out to $5 a person per year. Rather, it has the mission to organize

new and better programs, to fill in gaps, to undertake demonstrations and to raise standards.

It is difficult to assess the complete impact of the funding cuts on people and services because existing baseline data are poor, and future data will not be comparable due to changes in the reporting system. The states focus on serving those with the greatest need; thus the impact of reduced services will most likely fall on the recently unemployed, the working poor or the moderately handicapped. Tragically, recent reports have been made of increased infant mortality in some states indicating areas of compromised services. Furthermore, if one projects from California's experience with Proposition 13, reductions in prenatal care, family planning, well-child care and immunization programs can be anticipated as well as the associated morbidity that comes with such reductions.

RECOMMENDATIONS

Mr. Chairman, through your leadership and persistence you are probing for answers to the simple question of what has been the impact of budgetary cuts in the maternal and child health block grant, and by your actions you stand ready to correct any compromising situations, whatever those situations may be. We applaud your efforts to increase the funding level for maternal and child health programs for the short term. Evidence indicates that such an action is essential. But

perhaps initiatives to create a federal structural change, such as suggested in your resolution S. Res. 237, will give us and the Congress flexible and appropriate child health policy and strategy for the long term.

As stated in your introductory remarks of October 3, "As a first step toward better child health in America, we need a focal point of Federal efforts to promote child health and well-being. I believe the President should assign major new responsibilities to the Children's Bureau with DHHS to gather data on the status of children in America, to prepare comprehensive reports annually to Congress on the status of children, how Federal programs are affecting that status and to coordinate issues within the Federal Government and the Nation dealing with child health, nutrition, education, and other related children's issues." Currently, we simply do not have the governmental structure or necessary research tools, specifically data on child health status, to even begin to develop a sound child health policy.

We welcome this opportunity to present testimony on the maternal and child health programs, particularly since Congress has not reviewed these programs in detail since the late 1960s. Child health cannot be viewed in a vacuum. Congress must review in detail its myriad of patchwork programs constituting child health policy to determine their

efficiency and effectiveness. It is apparent that American children today do not have the same problems as children 15 or 20 years ago, because they are not the same kind of children. Congress must develop public policy and strategy to address the children of the 1980s. At a minimum, we need answers to the following questions: What are the goals and objectives of the various child health programs? Are they meeting these objectives? What are the gaps? Where is the overlap? Are these services appropriately integrated, or do they serve to further fragment child health care? At what expense are states undertaking cost shifting to make up budget deficits? How about standards of care? Access to care? To summarize, the health needs of a maternal and child population cannot be met simply by a series of disease or income-directed projects. The health of mothers and children cannot be equated simply with being ill, with being hospitalized, with being handicapped or even with being poor. Maternal and child health services involve setting of standards, development and deployment of resources, demonstrations of new and improved arrangements for assessment of care, and delineation of resources required in terms of facilities, personnel and financing. S. Res. 237 or some similar proposal would begin the important effort to answer these critical policy questions.

Mr. Chairman, the ultimate goal of all public health programs for mothers and children should be to maximize the quality of

services delivered, maximize access to persons in need, maximize efficiency in the delivery of these services and to accomplish these in a cost-effective manner. The American Academy of Pediatrics stands ready to assist you in this pursuit.

Thank you.

Senator BENTSEN. Dr. Osgood, looking at these nine States on the infant mortality data chart [indicating], we see an increase in infant mortality rates from 1981 to 1982 in each of these nine States. That increase is a reversal of the previous trend in these States, isn't it?

Dr. OSGOOD. Absolutely.

Senator BENTSEN. Infant mortality rates have turned around and starting back up again. Now, in 1983, States had some carryover of funds from the previous year's MCH appropriations, so the administration's MCH cuts did not have a substantial immediate impact on infant health in many cases.

You are the experts. What do you think is going to happen when you reach out beyond 1983? Do you think we will see this kind of a reversal in infant health continue for a while as a result of these kinds of cuts?

Dr. OSGOOD. Well, we already have some evidence that that is going to continue. The reversal will continue. In California, they had an experience with their Proposition 13. The results are pretty much in now. The results indicate that there was a reduction in prenatal care services, family planning services, well-child care, and immunization services, and a rise in all of the associated morbidity and mortality that was associated with it. That is on the record.

Senator BENTSEN. So you think these numbers from 1981 to 1982 and going on to 1983, the extrapolation of them will show the negative trend continuing?

Dr. OSGOOD. I think that is reasonable to expect.

Senator BENTSEN. Dr. Nelson, please proceed.

STATEMENT OF RICHARD P. NELSON, M.D., ASSISTANT PROFESSOR OF PEDIATRICS AND PUBLIC HEALTH, UNIVERSITY OF MINNESOTA; ALSO ASSOCIATED WITH GILLETTE CHILDREN'S HOSPITAL, ST. PAUL, MINN.

Dr. NELSON. Senator Bentsen, my verbal testimony today will focus on the efforts of the maternal and child health block grant programs to improve the health of children with chronic illness and disability.

The maternal and child health block grant programs are public health programs. They do many things, in planning, coordination of services, evaluation, and so forth. I think the interest today is documenting some of the impacts of service cuts as a result of the block grant program, and my testimony will emphasize that.

In States with limited medicaid eligibility and large low-income populations, the title V State maternal and child health programs are generally a primary source of direct services or health care payment for handicapped children whose families do not have adequate insurance or personal resources to obtain the health care that they need.

During fiscal year 1981, the last preblock grant year, the crippled children's services programs provided health care to over 605,000 children throughout the United States. We do not as of yet have any national data base beyond fiscal year 1981 to show major trends. But let me share with you some examples of what has happened in Minnesota as a result of the block grant cuts in terms of services to handicapped children.

The Minnesota Crippled Children's Agency has been unable to adjust its financial eligibility scale since 1977. The scale is based on median State income. Despite an increase in that median income during the time, we know that the purchasing power for low-income families has really not improved. But with the financial eligibility scale in Minnesota remaining unchanged in absolute dollars, many families have been unable to qualify for services through the program that qualified prior to the block grant.

In 1983, there was a reduction of 27 percent in the number of families reapplying for services to the program. This does not indicate less need for the program. It simply indicates that families who had been eligible in the past were no longer eligible because they fell above the income ceiling and therefore, the program could not serve them.

Similarly, during this period, the program was able to authorize care for 30 percent fewer episodes of health care than during the previous year. This is a result of a number of factors, but especially the inflation in the cost of health care without commensurate increase in the resources to purchase that care.

We strongly recommend that funding be brought to preblock grant levels so that the populations of families historically served, let alone new groups of individuals, can, in fact, be helped through public funding.

Let me mention a bit about the limitation in scope of services. With the uncertain funding created by the block grant reductions in 1981, many State agencies have proceeded very cautiously in refilling positions in their programs. They have certainly not launched new initiatives to meet new problems or needs. And in many areas, the comprehensiveness of service has been decreased.

In Minnesota, our outreach clinic program, which provides diagnostic specialty care to children in the rural areas of the State, has been cut back. In the last year, there have been only 6,000 visits to clinics organized by the crippled children's program, in contrast to 7,500 visits just the year before.

This places a burden on families that would have been served in that way to travel, to see specialists at some distance with increased cost.

It is essential, we believe, that services to low-income mothers and children, including handicapped children, be restored to those levels prior to the block grant. The authorization for title V should be increased to the level of the current appropriation, which is $373 million, to a level including that appropriated through the emergency jobs bill, a total of $478.

As another testifier has mentioned, this does still not match the constant service dollars needs if we were to look at 1980 dollars where title V programs would really need over $600 million simply to continue what they had been doing prior to the block grant.

We do not feel that title V needs to be revised at this point, but simply hope that the Congress will respond to the needs of mothers and children, including handicapped children, for services to maintain health status.

Thank you.

[The prepared statement of Dr. Nelson follows:]

PREPARED STATEMENT OF RICHARD P. NELSON, M.D.

I am Dr. Richard P. Nelson, Assistant Professor of Pediatrics and Public Health at the University of Minnesota and Gillette Children's Hospital, St. Paul; and Medical Consultant to the Services for Children with Handicaps Program in the Minnesota Department of Health.

Legislative Mandate Under the Block Grant

The legislation creating the Maternal and Child Health Services Block Grant in 1981 specified four purposes for the amended Title V of the Social Security Act. The purposes are as follows:

1. To assure mothers and children (in particular those with low income or with limited availability health services) access to quality maternal and child health services.

2. To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children... and to promote the health of mothers and children.

3. To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (Supplemental Security Income).

4. To provide services for locating, and for medical, surgical, corrective, and other services, ... for children who are crippled or who are suffering from conditions leading to crippling.

These objectives provide the compelling frame work for state maternal and child health programs. The agenda for these programs is nothing less than a continued improvement of the health of child-bearing and rearing women and their children. The programs function in a context of a complex health care industry including diverse practitioners, facilities, and public and voluntary programs.

My testimony to you today will focus on the efforts of MCH block grant programs to improve the health of mothers and children, including children with chronic illness or disability. In all states these programs continue to function after the block grant but a struggle with inadequate resources. Since I have been deeply involved with the Title V Minnesota Crippled Children's Program, my primary focus will be services for children with chronic illnesses or disabilities.

Program Mission Under the Block Grant

The maternal and child health block grant programs are public health programs and their mission has been and is to promote the development of the system of health care for all mothers and children. This mission involves the performance of a variety of

functions including planning, coordination of services, standard setting, the introduction of innovative methods of health care in to the service delivery system, training and education, and the provision of direct service and outreach.

1. Planning:

Title V maternal and child health state agencies must continually assess emerging health care needs of mothers and children. These needs may be state-wide or limited to specific geographical areas or socioeconomic groups. Problem identification, evaluation, and program design are among the tasks necessary for effective planning. During recent years agencies have been involved in numerous new efforts, including accident prevention, development of services to special ethnic populations including Southeast Asian immigrants, and the design of home care for technology-dependent children. With the creation of the Title V maternal and child health block grant and the consolidation of maternal and child health programs under Title V, the Title V maternal and child health state agencies have been able to expand and more effectively carry out their planning function.

2. Coordination:

There are an array of public programs designed to meet the specific health and welfare needs of children. With the exception of the maternal and child health programs most of the these efforts are limited in scope. The Title V maternal and child health state agencies have provided a locus around which the efforts of public programs can function without specific statutory authority over the resources of these programs; these agencies can and do act as a bridge between the public programs and the private health care sector. The leadership of these agencies have been effective in a number of arenas, including the development of early intervention services for preschool children, improvement in perinatal coordination of care among hospitals, and the innovative formation of multi-specialty health care teams for handicapped children.

3. The maintenance of standards:

The complexity of health care and latitude of individual practice create an unfortunate tendency to variability in scope and quality of service. Through the development of guidelines of care and the building of consensus among

providers, the maternal and child health programs have been successful in creating expectations for quality services in many states. Examples include the structure of perinatal referral systems, the review and designation of pediatric cardiac centers, and the prescription for scope of services for chronic conditions such as juvenile diabetes mellitus.

4. Innovation:

Title V maternal and child health block grant programs have played a major role in the introduction of new and better methods of care into the health care delivery system for mothers and children. One example is the regional Hemophilia Centers which provide comprehensive coordinated care for individuals with hemophilia. Another example is the Genetics Projects which have been instrumental in creating newborn metabolic screening programs and instituting genetic counseling and educational programs which reflect the latest knowledge in the field of genetics.

5. Education and Training:

The Title V maternal and child health programs conduct and support a variety of training and educational programs for health professionals and professionals from allied fields. A primary example are the perinatal education programs which have been created in many states. Other examples are

specific projects of regional and national significance such as the university affiliated programs for the developmentally disabled and the pediatric pulmonary centers. Many of these programs also pay for inpatient maternity care and inpatient newborn care for mothers and children who lack adequate public or private third party reimbursement for such care.

The Title V state crippled children's program has historically had a mandate to provide specialized health care as well as support services for handicapped and chronically ill children. These children often require highly specialized care which is simply lacking in their home communities, and accordingly state crippled children's programs have established specialty outpatient clinics to meet the needs of this population. Moveover, these children often require a wide variety of services from professionals of different disciplines, and so state crippled children's programs have increasingly provided case management as well as support services to this population. Finally, the care of the children is often quite costly and even children who have public or private third party coverage may not have adequate coverage given the cost of care. This, most state crippled children's programs pay for care for this population when third party coverage is lacking or inadequate.

6. Direct Service:

Considerable effort and resources are deployed to provide health care services and related services to mothers and children through the Title V maternal and child health block grant program. In states with limited Medicaid eligibility and large low-income populations, the Title V state maternal and child health programs are generally the only source of direct services for mothers and children who do not have adequate insurance or personal financial resources to obtain needed health care. Moreover, there are localities within states where private health providers are simply unavailable, and there are communities and within states when private health providers are unable or unwilling to furnish care to Medicaid eligible women and children. Hence, the state maternal and child health programs have developed maternity and child health clinics which provide prenatal care, newborn care, and well child care including immunizations, developmental assessments and vision and hearing screening.

During fiscal year 1981, the Crippled Children's Services programs provided services to 605,582 children. A large majority of these children, almost 570,000, receive their services through cost effective ambulatory care. For children requiring more intensive surgical or medical treatment, inpatient services were provided to 94,851 children, involving over 711,000 patient days of care.

In addition, several of the programs consolidated in the maternal and child health block grant programs in 1981 aredirect service programs. These programs include the Sudden Infant Death Program, the Lead Poisoning Program, the Hemophilia Program and the Genetics Program.

Impact of Federal Funding Cuts

The Omnibus Budget Reconciliation Act of 1981, the parent legislation for Maternal and Child Health Services Block Grant, generally reduced the overall allocation of federal dollars to the states by approximately 18%. This reduction occurred at a time when many states were experiencing severe difficulties in their own budgets. Further specific constraints were placed on maternal and child health activities due to inflation of costs in the health care sector which at that time continued at double-digit rates.

The funding reductions created a milieu of uncertainty in many states. State health commissioners and other decision makers wondered about the longevity of maternal and child health grants and this discouraged further program development or innovation.

The creation of the block grant funding mechanism also suggested to some providers and agencies that "new money" had suddenly been provided to states for new activities not previously funded under Title V.

Out of this environment of uncertainty several trends have emerged. I would like to provide several examples from this State of Minnesota which illustrate the impact of funding, and indicate why current funding of Title V is not adequate.

1. Decreased eligibility for perinatal programs.

Following reduction of funds to support maternal and child health programs administered by the Minneapolis Health Department, eligibility was reduced which excluded hundreds of low-income women from services that had been available for decades. Despite the prior demonstration of the effectiveness of these programs to diminish the frequency of low birth weight in their target areas. The potential for the health department to serve this needy population was compromised. Many women, including those from ethnic minorities, were not able to obtain recommended prenatal care without utilizing their very limited discretionary income.

In St. Paul the successful efforts to reach adolescent pregnant young women through high school clinics were also limited due to decreased funding.

Funds be restored to pre-block grant levels, at a minimum, to reinstitute the services available for this target population.

2. Reduced eligibility for children with chronic illness and handicaps.

The Minnesota Crippled Children Services Agency (Services for Children with Handicaps) has been unable to adjust its financial eligibility scale since 1977. Despite an increase in median family income in the state during this time, the purchasing power for low-income families has not improved. With the financial eligibility in absolute dollars unchanged more families have been unable to qualify for services through the program. In 1983 there was a reduction of 27% in the number of families re-applying for services as compared to 1981 (3,650 re-applications in contrast to 4,992 applications). This does not indicate less need for program services but the recognition by families that they no longer will qualify due to slight gains in their personal income. Similarly during this period the program was able to authorize for 30% fewer episodes of health care (6,461 versus

9,203) due to the increase cost of individual episodes of care without additional program resources.

Funding needs to be brought to pre-block grant levels so that population of families historically served by these programs can obtain necessary services.

Limitation in scope of services

Many clinics and professional services provided by Crippled Children Services Agencies have been limited since the introduction of the block grant. With the uncertain funding milieu staff positions in Minnesota have not been filled, new needs have not been addressed, and in some areas the comprehensiveness of care has been decreased. In Minnesota the number of visits to program outreach clinics throughout the state has declined from approximately 7,500 to 6,000 annually during the past two years secondary to a reduction in the number of clinic sites that could be funded with available program dollars.

It is essential to restore services to low-income mothers and children is that funding levels, as permitted by authorization under Title V, should be increased to match the fiscal year 1983 appropriation ($373 million) plus the

supplemental appropriation through the emergency jobs bill ($105 million). This sum($478 million) still does not match the constant service funding of Title V if one would project the purchasing power of fiscal year 1980 dollars to those dollars in 1984. Title V would require over 600 million dollars if those criteria were to be applied.

The urgency of maintaining effort on behalf of mothers and children cannot be overstated. We have lost capability during the past two years and have the opportunity, with thematernal and child health agency structure in place, to restore necessary services through more appropriate funding.

Block Grant Changes

The Association for Maternal and Child Health and Crippled Children's Services Programs does not support any substantive amendments to the Maternal and Child Health block grant legislation (Title V of the Social Security Act) at the present time. The enactment of the Maternal and Child Health block grant legislation two years ago, and the accompanying substantial reduction in federal funding for Maternal and Child Health block grant programs, have produced significant changes in these programs in many states to which adjustments are still being made. New amendments to the Maternal and Child Health Services

Block Grant legislation might create significant dislocation in the administration and operation of the state MCH and CC programs. Furthermore, states have not had, as yet, sufficient experience with the MCH block grant legislation to allow a full and accurate assessment of its impact.

Senator BENTSEN. My problem is that I have a conflict with the Finance Committee considering some major legislation that I am very much involved in. Schedule conflict is one of the problems that we run into in the Congress, unfortunately, with having to serve on so many committees at the same time. This problem is magnified in the closing days of a session.

What you have given us this morning will be very helpful in establishing the record for improving the MCH appropriations level. We will cite some of the numbers and examples that you have presented here today.

If you will forgive me now, I must get to the other hearing. Thank you for appearing here this morning.

The subcommittee stands adjourned.

[Whereupon, at 10:55 a.m., the subcommittee adjourned, subject to the call of the Chair.]

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